

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15001

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Barrie

2. Date of Death

April 23, 2004

3. Time of Death

5:58 p^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

153-05-5448

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sep. 19, 1920

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7070 Cradle Walkway

10f. Zip Code

21046

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Peter Wichot

18. Mother's Name (First, Middle, Maiden Surname)

Catherine (Unavailable)

19a. Informant's Name/Relationship (Type, Print)

Joseph Barrie, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

786 Oakstump Drive, Millersville, MD 21108

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

Apr. 28,
2004

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy, Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Malignant Rhythmic
Due to (or as a consequence of):
b. Atherosclerotic cardiovascular disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Sudden
Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D22856

29d. Date signed (Month, Day, Year)

April 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry L. Levine, MD, 11055 Littleton Rd, Columbia, Maryland 21044

State
Registrar

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15002

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

William Joseph Bezwersky

2. Date of Death

Month Day Year
April 29, 2004

3. Time of Death

4:00 A M

4a. Facility Name (If not institution, give street and number)

920 Barnegat Lane

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

127-07-4406

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 30, 1920

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

920 Barnegat Lane

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1942-47

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4 yrs.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Postmaster

16b. Kind of Business/Industry

US Postal Service

17. Father's Name (First, Middle, Last)

Nazary Bezwersky

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Matyaszek

19a. Informant's Name/Relationship (Type, Print)

Margarite E. Bezwersky/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

920 Barnegat Ln., Annapolis, Maryland 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Cemetery

Date

5-3-04

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Prostate Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin B Knopf MD 900 Bestgate Road Suite 300 Annapolis, MD 21404

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15003

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Smith BAZLUKE

2. Date of Death

April

Day

21

Year

2004

3. Time of Death

11:50 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

009-10-8947

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 1, 1923

9. Birthplace (State or Foreign Country)

Vermont

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20014 Rosebank Way, Apt. 323

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

machinist

16b. Kind of Business/Industry

manufacturing

17. Father's Name (First, Middle, Last)

Samuel Bazluke

18. Mother's Name (First, Middle, Maiden Surname)

Martha Smith

19a. Informant's Name/Relationship (Type, Print)

Robert Bazluke, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Goshen Rd., Williamsburg, Mass. 01096

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory

Date

4/22/04

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott M. Munnich

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
3 weeks

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

STAFF PHYSICIAN

29c. License number

D0050882

29d. Date signed (Month, Day, Year)

4/22/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEAL PATALIVEHAIG, M.D. 1110 MEDICAL CAMPUS ROAD SUITE 107 HAGERSTOWN MD 21742

31. Date filed (Month, Day, Year)

APR 23 2004

32. Registrar's Signature

Karen H. Spade

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15004

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ronald George Cool

2. Date of Death
Month Day Year
April 27, 20043. Time of Death
7:20 A MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

519-46-6384

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 11, 1942

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Knoxville

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

530 East Mountain Road

10f. Zip Code

21758

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Non Commissioned Officer

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Richard Cool

18. Mother's Name (First, Middle, Maiden Surname)

Alyce May Edie

19a. Informant's Name/Relationship (Type, Print)

Shirley T. Cool / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

530 East Mountain Road Knoxville, Maryland 21758

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington Nat. Cemetery

Date

June 10,

2004

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.

1621 Opossumtown Pike Frederick, Maryland 21702

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. USUAL INTERSTITIAL PNEUMONITIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter on each line Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

3 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify)

9 Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation

2 Accident 6 Could not be determined

3 Suicide 4 Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D-57796

29d. Date signed (Month, Day, Year)

APRIL 27 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LALIT VERMA, FREDERICK MEMORIAL HOSPITAL, FREDERICK, MARYLAND

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15005

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edna Lee Cruze

2. Date of Death
Month Day Year
April 22, 20043. Time of Death
7:55 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director5. Social Security Number
220-16-52286. Sex
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)
87 Yrs.8. Date of Birth
Month Day Year
July 4, 19169. Birthplace (State or Foreign Country)
Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7912 Lockney Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank Williams

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Aston

19a. Informant's Name/Relationship (Type, Print)

Arthur D. Cruze/ husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7912 Lockney Avenue Takoma Park, Maryland 20912

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

W. Arundel Crematory

Date
April 25, 2004

20c. Location - City or Town, State

Odenton, Maryland

21. Signature of Funeral Service Licensee

Beverly L. Heckrotte M01251

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 2102923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive heart failure

Due to (or as a consequence of):

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Ischemic Cardiomyopathy

Due to (or as a consequence of):

d. Renal Failure

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Steven Tee

29c. License number

D46998

29d. Date signed (Month, Day, Year)

April 22, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Tee, MD 3415 Hamilton ST Hyattsville, MD 20782

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Steven H. Smith

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

AMEND ITEM #16a&b PER FH C832 6/14/03 JH

Certificate of Death

Reg. No.

2004 15006

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond clay SR

2. Date of Death

April 22 2004

3. Time of Death

12 40 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Howard County General

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

212-16-6283

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

May 18, 1911

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9389 All Saints Road

10f. Zip Code

20723

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Janitor DEVELOPER

16b. Kind of Business/Industry

CONSTRUCTION Maintenance

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Smith

19a. Informant's Name/Relationship (Type, Print)

Sharon Clay/granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5205 Hillwell Rd. Baltimore, MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Memorial 4/30/04

Date

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

S. E. Miller

22. Name and Address of Facility

Miller's Metropolitan Chapel 1922 Forest Dr. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. prostate cancer

Approximate Interval Between Onset and Death

< 1 week

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

N/A

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

N/A

23d. Date of delivery

Month Day Year

N/A

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Brown Hematuria

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harry Li, M.D.

29c. License number

D56531

29d. Date signed (Month, Day, Year)

April 22, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li, M.D. 5755 Cedar Lane, Columbia, MD 21044

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15007

1- For
State
Registrar

| | | | | | |
|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ronny Hall Combs | | 2. Date of Death Month Day Year April 25 2004 | | 3. Time of Death 11:30AM |
| | 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital | | 4b. City, Town, or Location of Death Prince Frederick | | 4c. County of Death Calvert |
| Funeral Director | 5. Social Security Number 229 52 2450 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 62 Yrs. | 8. Date of Birth (Month, Day, Year) June 5 1941 | 9. Birthplace (State or Foreign Country) West Virginia |
| | 10a. State Maryland | | 10b. County Calvert | | 10c. City, Town or Location Prince Frederick |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 4905 Sandy Point Road | | 10f. Zip Code 20678 |
| | 10g. Citizen of What Country? United States | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (14 or 5+) |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Union Carpenter | | 16b. Kind of Business/Industry Construction | | 17. Father's Name (First, Middle, Last) Louis Hall Combs |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Vivian See | | 19a. Informant's Name/Relationship (Type, Print) Phyllis Miller Combs- wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4905 Sandy Point Road Prince Frederick MD 20678 |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Dale Church Cemetery | | 20c. Location - City or Town, State Baker West Virginia |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee B. Brousch | | 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. rd. Port Republic MD 20676 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE CORONARY ARTERY DISEASE Approximate Interval Between Onset and Death FEW YEARS |
| | 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia (R) Lower Lobe Insulin Dependent Diabetes Mellitus | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier ATM... M.D. Physician |
| | 29c. License number D 19427 | | 29d. Date signed (Month, Day, Year) 4/25/04 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR MUNSHT - Prince Frederick MD 20678 |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature B. Brousch | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural" or items 23a or 28e-f show any injury or other traumatic event. The Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Certificate of Death

Reg. No.

2004 15008

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Robert Van Downing

2. Date of Death

Month Day Year
April 18, 2004

3. Time of Death

3:12 a M

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

214-69-0324

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Jan. 21, 2004

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

17301 Tanyard Road

10f. Zip Code

20772

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Never Worked

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Donald Robert Downing

18. Mother's Name (First, Middle, Maiden Surname)

Christine Louise Robinson

19a. Informant's Name/Relationship (Type, Print)

Debra Wyvill/Aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12540 Plantation Ct., Dunkirk, MD 20754

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crem.

Date

4/20/2004

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Raymond-Wood Funeral Home

PO Box 430, Dunkirk, MD 20754

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sudden Unexplained Death in Infancy (SUDI)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year)

4/18/04

28b. Time of Injury

2:15 a M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

residence

28f. Location (Street and Number or Rural Route Number, City, Town, State)

17301 Tanyard Rd., Upper Marlboro, Prince George's County, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. IL HO GAN

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 22 2004

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15009

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Virgil

Dawkins

2. Date of Death

April 20, 2004

3. Time of Death

1:55A M

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

214-28-4214

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

Apr. 2, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

95 Central Drive

10f. Zip Code

20678

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Virgil

Dawkins

18. Mother's Name (First, Middle, Maiden Surname)

Ada

Harris

19a. Informant's Name/Relationship (Type, Print)

Virgil C. Dawkins/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

814 Crawford St. Oxon Hill, MD 20745

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chelt. Vet. Cem.

Date

4/26/2004

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

▶ Gladys G. Sewell

22. Name and Address of Facility

Sewell Funeral Home
1451 Dares Beach Rd.
Prince Frederick, MD 2067823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

b. MRSA BACTEREMIA

Due to (or as a consequence of):

c. DECUBITUS ULCERS

Due to (or as a consequence of):

d. CVA

Approximate
Interval Between
Onset and Death

10 DAYS

8 DAYS

2-3 MONTHS

MONTHS

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ J. Bush

29c. License number

D0060475

29d. Date signed (Month, Day, Year)

4/20/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TEREZIA BUSH, MD 100 HOSPITAL RD, PRINCE FREDERICK MD 20678

31. Date filed (Month, Day, Year)

APR 23 2004

32. Registrar's Signature

▶ J. Bush

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

3+1

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15010

1- For
State
Registrar

| | | | | | | | | | | |
|---|---|--|---|--|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARY A. DASHPER | | | | | 2. Date of Death Month 04 Day 28 Year 04 | | 3. Time of Death 1:40a^M | | |
| | 4a. Facility Name (If not institution, give street and number) Civista Medical Center | | | | | 4b. City, Town, or Location of Death LaPlata | | 4c. County of Death Charles | | |
| Funeral Director | 5. Social Security Number 222-01-1097 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV 17 1917 | | 9. Birthplace (State or Foreign Country) Delaware | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Charles | | 10c. City, Town or Location Waldorf | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 2719 Lois Court | | | | 10f. Zip Code 20603 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | 16b. Kind of Business/Industry Private | | |
| | 17. Father's Name (First, Middle, Last) Herman O. Edwards | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Cora Thompson Edwards | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Dale S. Ehrenstein (Niece) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5415 Lucy Drive Waldorf, Maryland 20601 | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 4-29-04 | | 20c. Location - City or Town, State Alexandria, VA | | | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> M00173 | | 22. Name and Address of Facility Eberwein Funeral Services 4433 White Pls. La. White Pls., MD 20695 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia | | | | | | | | Approximate Interval Between Onset and Death | |
| | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier <i>[Signature]</i> | | | | | 29c. License number D-21031 | | 29d. Date signed (Month, Day, Year) 4/28/04 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Leatherwood, MD 12070 Old Line Center Waldorf, MD 20602 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) APR 30 2004 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15011

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Ruth R. Edwards | | | | 2. Date of Death Month Day Year April 26 2004 | | 3. Time of Death 7:55 AM | |
| 4a. Facility Name (If not institution, give street and number) JULIA MANOR HEALTH CARE CENTER | | | | 4b. City, Town, or Location of Death HAGERSTOWN | | 4c. County of Death WASHINGTON | |
| 5. Social Security Number 287-09-0864 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV. 27, 1911 | |
| 9. Birthplace (State or Foreign Country) OHIO | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County WASHINGTON | | 10c. City, Town or Location HAGERSTOWN | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 333 MILL STREET | | | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME ECONOMIST | | 16b. Kind of Business/Industry POWER AND LIGHT CO. | |
| 17. Father's Name (First, Middle, Last) SMILEY RICHARD RAWLINS | | | | 18. Mother's Name (First, Middle, Maiden Surname) EDITH MAE GARRETT | | | |
| 19e. Informant's Name/Relationship (Type, Print) ROBERT W. EDWARDS, JR, SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5423 Porterstown Road, Keedysville, MD 21756 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SMITHSBURG CREMATORY | | Date 4/27/04 | | 20c. Location - City or Town, State SMITHSBURG, MARYLAND | |
| 21. Signature of Funeral Service Licensee Reilly A. Zimmerman | | | | 22. Name and Address of Facility BAST FUNERAL HOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Bullous Dermatitis Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier James M. Mumshe | | | | 29c. License number D0060396 | | 29d. Date signed (Month, Day, Year) 04/26/04 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) FARID MUMSHE | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | | | 32. Registrar's Signature James B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15012

1- For
State
Registrar

| | | | | | |
|---|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VIRGINIA H. FEDERLINE | | 2. Date of Death Month Day Year APRIL 24 2004 | | 3. Time of Death 0345 AM |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death NONE |
| Funeral Director | 5. Social Security Number 214 12 0488 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | 8. Date of Birth (Month, Day, Year) AUG 26, 1919 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Howard | 10c. City, Town or Location Ellicott City | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 3258 Normandy Woods Drive Apt C | | 10f. Zip Code 21043 | | 10g. Citizen of What Country? United States |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auditor | | 16b. Kind of Business/Industry Retail | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Charles Hilleary | | 18. Mother's Name (First, Middle, Maiden Surname) Hallie Runkles | | |
| | 19a. Informant's Name/Relationship (Type, Print) Barbara M. Miller/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2301 Gillis Road Mt. Airy, MD 21771 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Cemetery | | 20c. Location - City or Town, State 4-27-2004 Mt. Airy, MD |
| | 21. Signature of Funeral Service Licensee Sam Collins | | 22. Name and Address of Facility Harry H. Witzke's Family FH 4112 Old Columbia Pike Ellicott City, MD | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS Due to (or as a consequence of): PNEUMONIA Due to (or as a consequence of): CONGESTIVE HEART FAILURE Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 24 hours 48 hours 7 days | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier JASON A. WILLIAMS, M.D. | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) APRIL 24, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JASON A. WILLIAMS 600 N. WOLFE STREET BALTIMORE, MD 21287 | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature Brian K. Smith | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15013

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH ANNA FREDRICKSEN

2. Date of Death

April 21 2004

3. Time of Death

9:05p.M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

REEDERS MEMORIAL HOME

4b. City, Town, or Location of Death

BOONSBORO

4c. County of Death

WASHINGTON

5. Social Security Number

318-20-1445

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 12, 1916

9. Birthplace (State or Foreign Country)

ILLINOIS

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

141 S. MAIN STREET

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

SHIPPING CLERK

16b. Kind of Business/Industry

PART MANUFACTURER

17. Father's Name (First, Middle, Last)

HUGO FRED PETTER

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET ANNA RHINE

19a. Informant's Name/Relationship (Type, Print)

KAREN TALBOT, GRANDDAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

410 MT. HOPE ROAD, FAIRFIELD, PA 17320

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

SMITHSBURG CREMATORY

Date

4/23/2004

20c. Location - City or Town, State

SMITHSBURG, MARYLAND

21. Signature of Funeral Service Licensee

Kerry A. Zimmerman

22. Name and Address of Facility

EAST FUNERAL HOME

7606 OLD NATIONAL PIKE

BOONSBORO, MARYLAND 21713

23a. Part I. Enter disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic cancer, primary unknown

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Robert Guedenet

29c. License number

032518

29d. Date signed (Month, Day, Year)

4/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Robert Guedenet 21 Wyand Dr. Keedysville, M.D. 21756 / 301-432-2225

31. Date filed (Month, Day, Year)

APR 23 2004

32. Registrar's Signature

Karen D. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Name: Fredricksen
Baltimore, Maryland 21215-0036
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

DHHM 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 15014

| | | | | | |
|---|---|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Howard D. Fugitt, SR.</i> | | 2. Date of Death Month <i>04</i> Day <i>28</i> Year <i>2004</i> | | 3. Time of Death <i>10:04 PM</i> |
| | 4a. Facility Name (If not institution, give street and number.) <i>1015 Mastline Dr.</i> | | 4b. City, Town, or Location of Death <i>Annapolis</i> | | 4c. County of Death <i>Anne Arundel</i> |
| Funeral Director | 5. Social Security Number <i>579-10-7034</i> | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>83</i> Yrs. | 8. Date of Birth (Month, Day, Year) <i>1-5-1921</i> | |
| | 9. Birthplace (State or Foreign Country) <i>Maryland</i> | | | | |
| To Be Completed by Funeral Director | 10a. State <i>Maryland</i> | | 10b. County <i>Anne Arundel</i> | | 10c. City, Town or Location <i>Annapolis</i> |
| | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number <i>1015 Mastline Dr.</i> | | 10f. Zip Code <i>21401</i> | | 10g. Citizen of What Country? <i>USA</i> |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1942-62</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i> |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>3 yrs.</i> College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Lt. Colonel</i> | | 16b. Kind of Business/Industry <i>U.S. Army</i> |
| | 17. Father's Name (First, Middle, Last) <i>Edward Fugitt</i> | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Rita Sheriff</i> | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>Betty A. Fugitt/ Wife</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1015 Mastline Dr., Annapolis, Maryland 21401</i> | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MD Veterans Cemetery</i> | | 20c. Location - City or Town, State <i>5-4-04 Crownsville, MD</i> |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility <i>George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037</i> | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. adenocarcinoma, unknown primary</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i> | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <i>M</i> | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>K. Kemmer MD</i> | | 29c. License number <i>D0059173</i> | | 29d. Date signed (Month, Day, Year) <i>4-29-04</i> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Kathleen Kemmer, 900 Bestgate Rd, #300, Annapolis, MD 21401</i> | | | | | |
| 31. Date filed (Month, Day, Year) <i>APR 30 2004</i> | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2004 15015

1- For
State
Registrar

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy L. Gladmon

2. Date of Death

Month Day Year
April 28, 2004

3. Time of Death

10:20 p^M

4a. Facility Name (If not institution, give street and number)

Millennium at South River

4b. City, Town, or Location of Death

Edgewater

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

578-22-5651

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
9-5-1924

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1501 Warfield Rd.

10f. Zip Code

21037

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

10th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

HUD-Federal Government

17. Father's Name (First, Middle, Last)

Harry S. Duvall

18. Mother's Name (First, Middle, Maiden Surname)

Esther I. Bean

19a. Informant's Name/Relationship (Type, Print)

Hewitt W. Maus, Jr./Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1501 Warfield Rd., Edgewater, MD 21037

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MD Veterans Cemetery

Date

5-3-04

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

Bronchial Pneumonia

Approximate
Interval Between
Onset and Death
1 month

b. Due to (or as a consequence of):

Chronic Bronchitis - COPD

10 years

c. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death Check only one

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D38563

29d. Date signed (Month, Day, Year)

April 29, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wayne R. Bierbaum MD 134 Owonsville Rd West River MD 20778

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15016

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Maria

Elena

Goins

2. Date of Death

Month

Day

Year

April

27,

2004

3. Time of Death

8:00A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

12601 Brunswick Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince Georges

5. Social Security Number

463-62-6860

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Dec. 29, 1935

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12601 Brunswick

Lane

10f. Zip Code

20715

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☒ Yes 2 ☐ No Specify: Mexican

14. Race - American Indian, Black, White, etc.

Specify: Hispanic

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

NASA

17. Father's Name (First, Middle, Last)

Pilar

Garza

18. Mother's Name (First, Middle, Maiden Surname)

Caroline

Garza

19a. Informant's Name/Relationship (Type, Print)

Donnel L. Goins/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12601 Brunswick Lane, Bowie, Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans

Cemetery

Date

4/30/2004

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home

16000 Annapolis Road, Bowie, Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin dependent diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D35820

29d. Date signed (Month, Day, Year)

4/28/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Eckberg M.D. 14300 Ballant Fox Lane #110 Bowie, MD 20715

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

Certificate of Death

Reg. No.

2004 15017

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH LENORA HENDERSON

2. Date of Death

April 22 2004

3. Time of Death

1240 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

215-42-2835

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JAN. 15, 1943

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND10b. County
WASHINGTON

10c. City, Town or Location

HAGERSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

55 EAST WASHINGTON STREET, APT. 411

10f. Zip Code

21740

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SEIBERT JAMES SHOEMAKER

18. Mother's Name (First, Middle, Maiden Surname)

ANNA MAE CATHERINE NETZ

19a. Informant's Name/Relationship (Type, Print)

DAVID J.S. MYEREZ, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

615 F COLLINWOOD PLACE, NEWPORT NEWS, VA 23602

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BOONSBORO CEMETERY APR. 26, 04

Date

20c. Location - City or Town, State

BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee

Kelly A. Zimmerman

22. Name and Address of Facility

7606 OLD NATIONAL PIKE
BAST FUNERAL HOME BOONSBORO, MARYLAND 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Carcinoma of Cervix (Squamous cell) 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Samuel Chan, MD

29c. License number

D36055

29d. Date signed (Month, Day, Year)

April 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

324 East Antietam Street Suite 200, Hagerstown MD 21740

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

B. Spivey

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 24e-f show injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15018

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Kevin John Hann

2. Date of Death

Month Day Year

4 24 04

3. Time of Death

0705 M

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore MD

4c. County of Death

Baltimore

5. Social Security Number

184-60-8280

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

37 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

08/07/1966

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

PA.

10b. County

Fulton

10c. City, Town or Location

McConnellsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

182 Hawks Hill Lane

10f. Zip Code

17233

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

John E. Hann

18. Mother's Name (First, Middle, Maiden Surname)

Helen D. Pittman

19a. Informant's Name/Relationship (Type, Print)

Helen D. Hann/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

182 Hawks Hill Lane, McConnellsburg, Pa 17233

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Union Cemetery

Date

4/27/04

20c. Location - City or Town, State

McConnellsburg, Pa.

21. Signature of Funeral Service Licensee

Fred C. Bernal MBE

22. Name and Address of Facility

1037 Dual Pl. Hagerstown, Md. 21740
Burner Trade Services., P.A.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Liver Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3+ days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. GI Bleed

Due to (or as a consequence of):

3+ days

c. Coagulopathy

Due to (or as a consequence of):

1+ day

d. Multorgan Failure

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Hann MD

29c. License number

29d. Date signed (Month, Day, Year)

4/24/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marion Massaro 100 Harborview Dr. #906 Baltimore MD 21230

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Karen B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **AMEND ITEM #29d PER PHY G831 5/11/04** **Certificate of Death**

Reg. No. **2004 15019**

| | | | | | | | | |
|---|--|---|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert Eugene Harmon, Sr. | | | | 2. Date of Death Month April Day 12 Year 2004 | | 3. Time of Death 3:15AM M | |
| | 4a. Facility Name (If not institution, give street and number) 11805 Crestwood Avenue S. | | | | 4b. City, Town, or Location of Death Brandywine | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 243-16-7160 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 23, 1922 | |
| | 9. Birthplace (State or Foreign Country) North Carolina | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Brandywine | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 11805 Crestwood Avenue S. | | 10f. Zip Code 20613 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1971 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Air Force Retired | | 16b. Kind of Business/Industry U.S. Government | | | |
| | 17. Father's Name (First, Middle, Last) Thomas Jefferson Harmon | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maude Padgett | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Robert E. Harmon, Jr. (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2610 Midway Branch Dr. Apt 102 Odenton, MD 21113 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) April 15, Maryland Veterans Cemetery 2004 Cheltenham, Maryland | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee [Signature] | | 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Small cell cancer of lung. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number 028352 | | 29d. Date signed (Month, Day, Year) 4-11-04 4/12/04 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P O Box 1703 La Plata Md 20646 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 13 2004 | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15020

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 905a.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Burton D. Hazel, Sr. | | | | 2. Date of Death Month April Day 24 Year 2004 | | 3. Time of Death 6:00 A^M | |
| 4a. Facility Name (If not institution, give street and number) Charlotte Hall Veterans Home | | | | 4b. City, Town, or Location of Death Charlotte Hall | | 4c. County of Death St. Mary's | |
| 5. Social Security Number 321-24-8516 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 4 1920 | |
| 9. Birthplace (State or Foreign Country) Canada | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Edgewater | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 41 Clairborne Road | | | | 10f. Zip Code 21037 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) superintendent | | 16b. Kind of Business/Industry construction | |
| 17. Father's Name (First, Middle, Last) Joseph Hazel | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Cronin | | | |
| 19a. Informant's Name/Relationship (Type, Print) Irene Hazel / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Clairborne Rd. Edgewater, MD 21037 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Crematory | | Date 4-28-04 | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee D. Scott Komarowski | | | | 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DEMENTIA | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEIZURE DISORDER, PARKINSON'S DISEASE CEREBROVASCULAR DISEASE, DIABETES MELLITUS II, HEMOCHROMATOSIS, ANEMIA, CATARACTS | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier D. Scott Komarowski | | | | 29c. License number D 50963 | | 29d. Date signed (Month, Day, Year) 04/26/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FULTON LUKBAN M.D., CHVH, CHARLOTTE HALL, MD | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | | | 32. Registrar's Signature [Signature] | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15021

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Laura Hummel

2. Date of Death

Month Day Year
April 23, 2004

3. Time of Death

7:45a M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

5. Social Security Number

169-18-7303

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 26, 1914

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

24 Truckhouse Road

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Samuel Magroski

18. Mother's Name (First, Middle, Maiden Surname)

Anna Bielski

19a. Informant's Name/Relationship (Type, Print)

Lucille Henault/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 White Oak Court Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Marys Cemetery

Date
April 26,
2004

20c. Location - City or Town, State

Reading, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy. Severna Park, MD 2114623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. SEVERE DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DYSPHAGIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M. Magroski, MD

29c. License number

D57531

29d. Date signed (Month, Day, Year)

APRIL 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Monitregi, 8661 Veterans Hwy, Midersville MD 21108

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

K. B. Smith

State
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

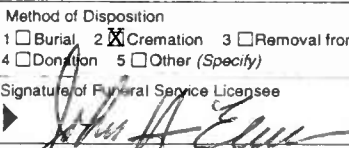

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **AMEND ITEM #23c PER PHY G831 5/10/04** Certificate of Death

Reg. No. **2004 15022**

| | | | | | |
|--|---|--|---|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EARL HAGGINS | | 2. Date of Death Month 04 Day 09 Year 04 | | 3. Time of Death 1249PM |
| | 4a. Facility Name (If not institution, give street and number) Howard County General Hospital | | 4b. City, Town, or Location of Death Columbia | | 4c. County of Death Howard |
| Funeral Director | 5. Social Security Number 579-42-1106 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 70 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) MAR 12 1934 | | 9. Birthplace (State or Foreign Country) North Carolina | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Prince George's | 10c. City, Town or Location Laurel | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number Cherry Lane Nursing Ct. 9001 Cherry Lane | | 10f. Zip Code 20708 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician | | 16b. Kind of Business/Industry Helath | | |
| | 17. Father's Name (First, Middle, Last) James Haggins | | 18. Mother's Name (First, Middle, Maiden Surname) Matilda Haggins | | |
| | 19a. Informant's Name/Relationship (Type, Print) Karl C. Haggins (son) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3811 Lakewood Place Waldorf, MD 20602 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 4-13-04 | | 20c. Location - City or Town, State Alexandria, VA |
| | 21. Signature of Funeral Service Licensee  M00173 | | 22. Name and Address of Facility Eberwein Funeral Srrvices 4433 White Pls. La White Pls., MD 20695 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS Approximate Interval Between Onset and Death weeks | | | | |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NOSOCOMIAL PNEUMONIA Approximate Interval Between Onset and Death weeks | | | | | |
| 23c. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ASPIRATION Approximate Interval Between Onset and Death weeks | | | | | |
| 23d. Part IV. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. STAGE IV pressure ulcers Acute Renal failure | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STAGE IV pressure ulcers Acute Renal failure | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier R. Elmer Attending MD 29c. License number DS0303 29d. Date signed (Month, Day, Year) 4/9/04 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rodolfo Fernandez 405 Frederick Rd Ste 162 Catonsville, MD 21228 | | | | | |
| 31. Date filed (Month, Day, Year) APR 13 2004 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15023

1- For
State
RegistrarPhysician
/Medical
Examiner1. Decedent's Name (First, Middle, Last) Mary Frances Higgins
2. Date of Death Month Day Year April 18, 2004
3. Time of Death 7:30p^MFuneral
Director4a. Facility Name (If not institution, give street and number) 14924 National Pike
4b. City, Town, or Location of Death Clear Spring
4c. County of Death Washington
5. Social Security Number 218-30-7787
6. Sex ☐ M ☒ F
7. Age (In yrs. last birthday) 71 Yrs.
8. Date of Birth (Month, Day, Year) June 26, 1932
9. Birthplace (State or Foreign Country) MarylandUsual Residence of Decedent
10a. State MD
10b. County Washington
10c. City, Town or Location Clear Spring
10d. Inside City Limits ☐ Yes ☒ No10e. Street and Number 14924 National Pike
10f. Zip Code 21722
10g. Citizen of What Country? U.S.A.11. Marital Status
1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc.
Specify: White15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
16b. Kind of Business/Industry House Wife / Home17. Father's Name (First, Middle, Last) Henry Kratz
18. Mother's Name (First, Middle, Maiden Surname) Ellen Kline19a. Informant's Name/Relationship (Type, Print) Lewis Higgins (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14924 National Pike Clear Spring, Md 2172220a. Method of Disposition
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Date Smithsburg Crematory 4/20/04
20c. Location - City or Town, State Smithsburg, Maryland21. Signature of Funeral Service Licensee
22. Name and Address of Facility Davis Funeral Home
12525 Bradbury Ave. Smithsburg, Md 21783Physician
/Medical
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular Accident
Approximate Interval Between Onset and Death weeksSequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Necrotic 4th and 5th Right toes weeks

c. Hypertension years

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown
23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown
23d. Date of delivery Month Day YearPart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23e. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)27. Manner of Death
1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)29a. Certifier
(Check only one)
29b. Signature and title of certifier
29c. License number MD0052136
29d. Date signed (Month, Day, Year) 04/20/0430. Name and address of person who completed cause of death (Item 23a) (Type, Print)
K. Bill Ciccarelli Williamsport Family Practice 3 Byrket Dr. Williamsport MD 21795State
Registrar31. Date filed (Month, Day, Year) APR 22 2004
32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15024

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ronald Wayne Jordan

2. Date of Death

Month Day Year
April 21 2004

3. Time of Death

4:19 P M

4a. Facility Name (If not institution, give street and number)

Homewood Nursing Home

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

220-30-9686

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Apr. 18, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12 S. Walnut St. Apt. 510

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Baker

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Russell Windfield Jordan

18. Mother's Name (First, Middle, Maiden Surname)

Claudia Amelia Perry

19a. Informant's Name/Relationship (Type, Print)

Tom Jordan - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7602 Neck Road Williamsport, Maryland 21795

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greenlawn Mem. Park Apr. 26, 2004 Williamsport, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home, P.A.
425 S. Conococheague St. Williamsport, MD 2179523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset of Death
Years

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CANCER OF LUNG WITH SPREAD METASTASES
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
CONGESTION HEART FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

Stephan E. Metcalley, MD

29c. License number

D17067

29d. Date signed (Month, Day, Year)

April 22, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHAN E. METCALLEY, MD

747 NORTHEAST AVE

HAGERSTOWN, MD

31. Date filed (Month, Day, Year)

APR 23 2004

32. Registrar's Signature

Karen S. Sparks

21742

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend #26, 4/28/04, fchd, SL Certificate of Death Reg. No. 2004 15025

| | | | | | | | | | | | | |
|---|---|--|---|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Grace Souder King | | | | 2. Date of Death Month Day Year April 26, 2004 | | | | 3. Time of Death 12:45 A^M | | | |
| | 4a. Facility Name (If not institution, give street and number) 26110 Ridge Road | | | | 4b. City, Town, or Location of Death Damascus | | | | 4c. County of Death Montgomery | | | |
| Funeral Director | 5. Social Security Number 577-10-7432 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) July 23, 1913 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | 10a. State Maryland | | | | 10b. County Montgomery | | 10c. City, Town or Location Damascus | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 26110 Ridge Road | | | | 10f. Zip Code 20872 | | | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Assistant | | | | 16b. Kind of Business/Industry Circuit Court of Maryland | | | |
| | 17. Father's Name (First, Middle, Last) Archie Souder | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sallie Purdum | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Daniel C. King - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26421 Mullinix Mill Road, Mount Airy, Maryland 21771 | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Damascus Meth. Cemetery 5/1/04 | | | | 20c. Location - City or Town, State Damascus, Maryland | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Robert L. Williams | | | | 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Non Hodgkin Lymphoma - Mantle Cell Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 4 Months | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Hospice | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | | | |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Paul Barren | | | | 29c. License number MD060335 | | | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year) April 26, 2004 | | | | | | | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive # 327 Olney, MD 20832 | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) APR 28 2004 | | | | 32. Registrar's Signature [Signature] | | | | | | | |
| | | | | | | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Reg. No. 2004 15026

Reg. No.

3. Time of Death
4:30 A M

Anne Arundel

Country)
Maryland

1 ☒ Yes 2 ☐ No

United States

Black, white, etc.

Davis Boat Co.

Bertha Sheckels

4124 Ashton Club Drive Lake Wales Fla. 33859

Solomons Maryland

1405 Brookes Is. Rd. Port Republic Maryland 20676

Approximate
Interval Between
Onset and Death
years

Due to (or as a consequence of):

23d. Date of delivery
Month Day Year

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ PCA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

29d. Date signed (Month, Day, Year)

Rebecca Elton MD 8601 Veterans Highway 7 MD 21108

32. Registrar's Signature

APR 22 2004

James H. Smith

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15027

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Peter Blackford Lauck

2. Date of Death

April 24, 2004

3. Time of Death

8:30 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

61 Southgate Avenue

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

578-22-6849

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

August 30, 1917

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

61 Southgate Avenue

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

editor

16b. Kind of Business/Industry

newspaper

17. Father's Name (First, Middle, Last)

William Jett Lauck

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Dunlap

19a. Informant's Name/Relationship (Type, Print)

Josephine Thoms/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

61 Southgate Avenue Annapolis, MD 21401

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Crematory

Date

Apr. 28, 2004

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

D Scott Romandi

22. Name and Address of Facility John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

WEAKNESS AND MALNUTRITION

Approximate Interval Between Onset and Death

1 Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

ALZHEIMER'S DEMENTIA

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

3 YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORD. ABSTIN. ADRENAL.
UTI HEMORRHOGE. D.D.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation
6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D Scott Romandi

29c. License number

D20142

29d. Date signed (Month, Day, Year)

4/26/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. DAVID KRIMINS, MD.

104 ROBERT AVE ANNAP.

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

D Scott Romandi

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15028

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harry Richard Lewis Sr.

2. Date of Death

April 22 2004

3. Time of Death

12:58 PM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

215-26-7725

6. Sex

M 2 F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 28, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

13307 Sandstone Dr.

10f. Zip Code

21783

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Installer

16b. Kind of Business/Industry

Floor

17. Father's Name (First, Middle, Last)

Roscoe Lewis Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Lewis

19a. Informant's Name/Relationship (Type, Print)

Elaine G. Lewis (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13307 Sandstone Dr. Smithsburg, Md. 21783

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Bethel Cemetery 2004

Date

20c. Location - City or Town, State

Foxville, Md.

21. Signature of Funeral Service Licensee

Dennis L. Davis

22. Name and Address of Facility

Davis Funeral Home
12525 Bradbury Ave.
Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Chronic obstructive pulmonary disease

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

sepsis syndrome
pneumothorax

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

no

29c. License number

D0054451

29d. Date signed (Month, Day, Year)

April, 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian Beham 22911 Jefferson Blvd Smithsburg, Maryland

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Karen B. Spivey

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No. 2004 15029

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GRACE AILEENE MULLENDORE

2. Date of Death
Month Day Year

APRIL 23 2004

3. Time of Death

335 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FAIRNEY-KEEDY NURSING HOME

4b. City, Town, or Location of Death

BOONSBORO

4c. County of Death

WASHINGTON

5. Social Security Number

214-46-5474

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98 yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

JUNE 7, 1905

9. Birthplace (State or Foreign
Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8507 MAPLEVILLE ROAD

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

OLIVER C. KNADLER

18. Mother's Name (First, Middle, Maiden Surname)

EDITH ROHRER

19a. Informant's Name/Relationship (Type, Print)

GLORIA HOUSER, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20336 LOCUST GROVE ROAD, ROHRERSVILLE, MD 21779

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MT. ZION CEMETERY

Date

APR. 26, 04

20c. Location - City or Town, State

ROHRERSVILLE, MARYLAND

21. Signature of Funeral Service Licensee

KELLY A. ZIMMERMAN

22. Name and Address of Facility

BAST FUNERAL HOME BOONSBORO, MARYLAND 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Congestive Heart Failure

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier,

29c. License number

00060396

29d. Date signed (Month, Day, Year)

4/23/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARID MURSHED

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

James B. Spivey

State
RegistrarGRACE "AILEENE" MULLENDORE
Baltimore, Maryland 21215-0036permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended #7 per FH FCHD, KS 5/3/00 Certificate of Death

Reg. No. 2004 15030

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Gladys Jeanette McCarvill | | | | 2. Date of Death Month April Day 27 Year 2004 | | 3. Time of Death 2:55 A^M | |
| | 4a. Facility Name (If not institution, give street and number) Shady Grove Hospital | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 217-46-5291 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 9, 1915 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Damascus | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number 25309 Woodfield Road | | 10f. Zip Code 20872 | |
| | 10g. Citizen of What Country? United States | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry own home | | 17. Father's Name (First, Middle, Last) William A. Windsor | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Amelia Jeannette Foreacre | | | | 19a. Informant's Name/Relationship (Type, Print) John McCarvill / Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25309 Woodfield Road, Damascus, MD 20872 | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven | | 20c. Location - City or Town, State Silver Spring, MD | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Robert L. Williams | | | | 22. Name and Address of Facility Olin L. Molesworth, P.A. Funeral Home 26401 Ridge Road, Damascus, MD 20872 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bilateral Aspiration pneumonia Due to (or as a consequence of): b. Right ankle ulcer with osteomyelitis Due to (or as a consequence of): c. Type II Diabetes Due to (or as a consequence of): d. Aortic stenosis | | | | Approximate Interval Between Onset and Death Days weeks years years | | | |
| To Be Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | |
| | 23d. Date of delivery Month Day Year | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day Year) April 27 2004 | | | | 28b. Time of Injury M | | | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Suhair H. Abulfarag, MD | | | |
| | 29c. License number D31391 | | | | 29d. Date signed (Month, Day, Year) April 27 2004 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suhair H. Abulfarag, MD 15215 Shady Grove Rd., #100, Rockville, MD 20850 | | | | 31. Date filed (Month, Day, Year) APR 28 2004 | | | |
| | 32. Registrar's Signature [Signature] | | | | 33. Date of Death 2004 15030 | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2004 15031

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) JOSEPH EDWARD MAY 2. Date of Death Month Day Year APRIL 25 2004 3. Time of Death 8.55a M

Funeral Director

4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital 4b. City, Town, or Location of Death Frederick 4c. County of Death Frederick

5. Social Security Number 220-20-2506 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 76 Yrs. 8. Date of Birth (Month, Day, Year) June 13, 1927 9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent 10a. State Maryland 10b. County Frederick 10c. City, Town or Location Thurmont 10d. Inside City Limits Yes No

10e. Street and Number #1 Sandy Spring Court 10f. Zip Code 21788 10g. Citizen of What Country? U.S.A.

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No 14. Race - American Indian, Black, White, etc. white

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder 16b. Kind of Business/Industry U.S. Government

17. Father's Name (First, Middle, Last) Joseph E. May 18. Mother's Name (First, Middle, Maiden Surname) Bessie Murray

19a. Informant's Name/Relationship (Type, Print) Anna May - wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #1 Sandy Spring Court, Thurmont, Maryland 21788

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Joseph's Cemetery 20c. Location - City or Town, State Emmittsburg, Maryland

21. Signature of Funeral Service Licensee Sharon Camille Colive 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure

Due to (or as a consequence of): Acute Renal Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis Advanced Dementia

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number D43091 29d. Date signed (Month, Day, Year) 4-26-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saad Zaidi MN 801 Toll House Ave, Frederick MD

31. Date filed (Month, Day, Year) APR 30 2004 32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended #3 per MD #5 per FH FCHD Certificate of Death KS

Reg. No. 2004 15032

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) GEORGE EDWARD MILES | | | | 2. Date of Death Month Day Year APRIL 21 2004 | | | | 3. Time of Death 9:29 PM 3:38 PM | |
| 4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death FREDERICK | | | | 4c. County of Death FREDERICK | |
| 5. Social Security Number 217-40-9133 217-10-9133 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | 8. Date of Birth (Month, Day, Year) March 14, 1917 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Buckeystown | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 6833 Buckingham Lane Box 27 | | | | 10f. Zip Code 21717 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Master Mechanic | | | 16b. Kind of Business/Industry Lime Company | | |
| 17. Father's Name (First, Middle, Last) William Francis Miles | | | | 18. Mother's Name (First, Middle, Maiden Surname) Flora Frances Ricketts | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) William E. Miles/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9208 Links Road Walkersville, MD 21793 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery | | 20c. Location - City or Town, State Frederick, MD | | 20d. Date 04/24/2004 | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Dilated Cardiomyopathy b. Pulmonary Fibrosis c. Atrial Fibrillation d. Renal Insufficiency | | | | | | | | Approximate Interval Between Onset and Death Yrs | |
| 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D36649 | |
| | | | | 29d. Date signed (Month, Day, Year) 4/23/04 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Edward Riuli 180 Thomas Johnson Dr. #202, Frederick, MD 21702 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15033

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Edna Mae Matthews

2. Date of Death

Month Day Year
April 25, 2004

3. Time of Death

7:05PM M

4a. Facility Name (If not institution, give street and number)

National Lutheran Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

279-42-3319

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 28, 1904

9. Birthplace (State or Foreign Country)

Lima Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10301 Gainsborough Road

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12thCollege (1-4 or 5+)
2+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Doctors Office

17. Father's Name (First, Middle, Last)

Henry F. Schwartz

18. Mother's Name (First, Middle, Maiden Surname)

Martha Harruff

19a. Informant's Name/Relationship (Type, Print)

Nancy Matthews (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3221 Coquelin Terrace, Chevy Chase, MD 20815

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory

Date
April 27, 2004

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

555. 5th 400542

22. Name and Address of Facility Lee Funeral Home, Inc.

6633 Old Alexandria Ferry rd Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sudden cardiac death
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension
Due to (or as a consequence of):

20 years

c. Chronic obstructive pulmonary disease
Due to (or as a consequence of):

20 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers Dementia 2

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samuel G. Maller

29c. License number

DS00612

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samuel G. Maller MD 3305 N. Leisure World, Blvd, Silver Spring, MD 20906

State
Registrar

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

Kara L. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

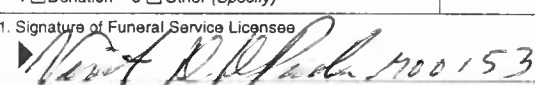
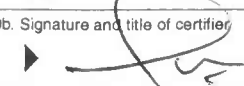
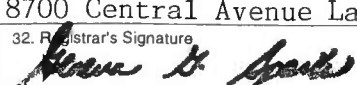
Certificate of Death

Reg. No.

2004 15034

1- For State Registrar

Physician /Medical Examiner
Funeral Director

| | | | | | |
|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Harold Lyndon Mauck | | 2. Date of Death Month April Day 23 , Year 2004 | | 3. Time of Death 12:20A M | |
| 4a. Facility Name (If not institution, give street and number) Millennium of Forestville | | 4b. City, Town, or Location of Death Forestville | | 4c. County of Death Prince George's | |
| 5. Social Security Number 577-09-2579 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | |
| 8. Date of Birth (Month, Day, Year) April 24, 1915 | | 9. Birthplace (State or Foreign Country) Virginia | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Forestville | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 6513 Lacona Street | | 10f. Zip Code 20747 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bakery Salesman | | 16b. Kind of Business/Industry Wonder Bread | |
| 17. Father's Name (First, Middle, Last) William Branson Mauck | | 18. Mother's Name (First, Middle, Maiden Surname) Zora Wilson Updike | | | |
| 19a. Informant's Name/Relationship (Type, Print) Sarah J. Mauck (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6513 Lacona Street Forestville, Maryland 20747 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. Location - City or Town, State Suitland, Maryland | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive Heart Failure Coronary Artery Disease Hypertension | | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | |
| 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Insufficiennncy | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> D/OA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  ATTENDING PHYSICIAN | | 29c. License number D0052900 | |
| 29d. Date signed (Month, Day, Year) 4-23-2004 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Musa M.D. 8700 Central Avenue Landover Maryland 20785 | | | | | |
| 31. Date filed (Month, Day, Year) APR 30 2004 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15035

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Jessie Meiklejohn | | | | 2. Date of Death Month April Day 25 Year 2004 | | 3. Time of Death 1:42 A M | |
| 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| 5. Social Security Number 239-38-8471 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | 8. Date of Birth (Month, Day, Year) May 1, 1928 | 9. Birthplace (State or Foreign Country) North Carolina | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 213 Janwall Street | | | | 10f. Zip Code 21403 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | 16b. Kind of Business/Industry own home | |
| 17. Father's Name (First, Middle, Last) Frank Ward | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lillie Bordughs | | | |
| 19a. Informant's Name/Relationship (Type, Print) Melissa Owens/ daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3827 Holly Drive Edgewater, MD 21037 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery | | 20c. Date 4-29-04 | | 20d. Location - City or Town, State Annapolis, MD | |
| 21. Signature of Funeral Service Licensee G. Scott Romanelli | | | | 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congestive Heart Failure | | | | | | | |
| 23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | | | | |
| 23d. Date of delivery Month Day Year | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier D. Wainston | | | | 29c. License number 1238445 | | 29d. Date signed (Month, Day, Year) 4/26/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Era Wainston 600 Ridgely Ave Annapolis, MD | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | | | 32. Registrar's Signature [Signature] | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15036

1- For
State
Registrar

| | | | | | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|--|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rinaldo B. Massimino | | | | 2. Date of Death Month Day Year April 25, 2004 | | | | 3. Time of Death 8:24 p^M | | | | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | | | 4c. County of Death Anne Arundel | | | | |
| Funeral Director | 5. Social Security Number 188-24-0991 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 22, 1930 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Severna Park | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number 600 McKinsey Park Drive Unit 506 | | | | 10f. Zip Code 21146 | | | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Music Teacher | | | | 16b. Kind of Business/Industry Anne Arundel County Public School System | | | | |
| | 17. Father's Name (First, Middle, Last) Enrico Massimino | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Troia | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Agnes Massimino/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21146 600 McKinsey Park Drive Unit 506 Severna Park, MD | | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | | | 20c. Location - City or Town, State Baltimore, MD | | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Vascular accident Due to (or as a consequence of): b. acute myocardial infarction Due to (or as a consequence of): c. atherosclerotic heart disease Due to (or as a consequence of): d. | | | | | | | | | | | | |
| | 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number D58510 | | | | 29d. Date signed (Month, Day, Year) 4/27/04 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Olexo 31 Robinson Rd. Severna Park MD 21146 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No. 2004 15037

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Lindbergh MACE

2. Date of Death
Month Day Year
April 22 2004 9:29 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

215-20-8500

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 26, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

260 Frederick Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

driver

16b. Kind of Business/Industry

county government

17. Father's Name (First, Middle, Last)

Charles I. Mace

18. Mother's Name (First, Middle, Maiden Surname)

Mary Yeakle

19a. Informant's Name/Relationship (Type, Print)

Frances M. Mace - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

260 Frederick Street, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

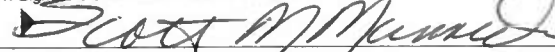
Date

4/27/04

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Squamous cell carcinoma of the lung

Due to (or as a consequence of):

b. Perforated toxic megacolon

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
UNKNOWN
~ 1 week

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Samir Kheiri MD

29c. License number

D0052064

29d. Date signed (Month, Day, Year)

04, 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMIR KHEIRI MD, 1130 OPAL COURT, HAGERSTOWN, MD 21742

31. Date filed (Month, Day, Year)

APR 23 2004

32. Registrar's Signature



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15038

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)

Patricia May Manious

2. Date of Death

April 19, 2004

3. Time of Death

9:30pm M

4a. Facility Name (If not institution, give street and number)

Reeders Memorial Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington County

5. Social Security Number

214-32-4278

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 31, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland Washington

10b. County

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

24 Chips Court

10f. Zip Code

21783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Industrial Engineer

16b. Kind of Business/Industry

Shoe Mfg.

17. Father's Name (First, Middle, Last)

Clarence M. Manious

18. Mother's Name (First, Middle, Maiden Surname)

Stella May Carbaugh

19a. Informant's Name/Relationship (Type, Print)

Vickie Sampson/Caregiver

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

316 Kamelot Blvd., Falling Waters, WV 25419

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem. Pk. April 22, 2004 Maryland

Date

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Daniel A. Pauley Jr. MD1393

22. Name and Address of Facility

Douglas A. Fiery Funeral Home
1331 Eastern Blvd. North, Hagerstown, MD 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

3 ☐ Ectopic pregnancy

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Zafar Malik

29c. License number

D44996

29d. Date signed (Month, Day, Year)

April 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zafar Malik, 20311 Lappans Rd., Boonsboro, MD 21713 301-432-8470

31. Date filed (Month, Day, Year)

APR 22 2004

32. Registrar's Signature

James B. Spivey

State Registrar

Name: Manious, Patricia
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15039

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)

Kirk Joseph Oxendine

2. Date of Death

Month Day Year April 26, 2004

3. Time of Death 05:28 AM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

216-742918

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) June 1, 1964

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17938 Clubhouse Drive

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Correctional Officer

16b. Kind of Business/Industry

Correctional Institution

17. Father's Name (First, Middle, Last)

Lawson Oxendine

18. Mother's Name (First, Middle, Maiden Surname)

Mary Helen Hawkins

19a. Informant's Name/Relationship (Type, Print)

Lori Dawn Oxendine/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17938 Clubhouse Dr. Hagerstown, MD 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

4/29/2004

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Stephen M. Sign

22. Name and Address of Facility

Rest Haven Funeral Chapel

1601 Pennsylvania Ave. Hagerstown, MD 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Disseminated Undifferentiated Sarcoma

Approximate Interval Between Onset and Death 5 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Hind Hamdan, MD

29c. License number

D46473

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hind Hamdan, MD; 1130 OPAL CT., Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Sharon B. Spivey

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15040

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Violet Louise Osborne

2. Date of Death

Month Day Year
APRIL 23 2004 8:50 PM

3. Time of Death

Funeral Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

216-88-4484

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 25, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

62 East Franklin Street

10f. Zip Code

21740

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jessie T. McDonald

18. Mother's Name (First, Middle, Maiden Surname)

Maude E. Smith

19a. Informant's Name/Relationship (Type, Print)

Thomas Osborne, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

50 Hamilton Ave. Frederick, MD 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Crematory

Date

April 26, 2004

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Resthaven Funeral Services, Skkot Cody P.A.
9501 Catoctin Mtn. Hwy. Frederick, MD 21701

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Fair m...
FARID MURSHED

29c. License number

D0060396

29d. Date signed (Month, Day, Year)

4/24/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1126 Opal Court Hagerstown Maryland

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Benita S Sparks

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23b or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15041

1- For
State
Registrar

| | | | | | | | | | |
|--|---|--|---|--|--|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Barbara Pierce | | | | 2. Date of Death Month Day Year April 24, 2004 | | 3. Time of Death 9:30a M | | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 221-24-9795 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | 8. Date of Birth (Month, Day, Year) Nov. 20, 1939 | 9. Birthplace (State or Foreign Country) Delaware | | | | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Anne Arundel | 10c. City, Town or Location Annapolis | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number 956 Woodland Circle | | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse | | 16b. Kind of Business/Industry Medical | | | | |
| | 17. Father's Name (First, Middle, Last) John D. Kimney | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edna M. Warren | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Chris Pierce/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 956 Woodland Circle Annapolis, MD 21401 | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Location - City or Town, State Baltimore, MD | | 20d. Date April 28, 2004 | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death Months | | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (Specify) | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OIA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D37064 | | 29d. Date signed (Month, Day, Year) 4/26/04 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Chamberlain, MD 277 Peninsula Farm Rd Arnold, MD 21012 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15062

| | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Justin Charles Poss | | | | 2. Date of Death Month Day Year APRIL 24, 2004 | | | | 3. Time of Death 7:17 P M | |
| | 4a. Facility Name (If not institution, give street and number) SOLLARS WHARF ROAD | | | | 4b. City, Town, or Location of Death LUSBY | | | | 4c. County of Death CALVERT | |
| Funeral Director | 5. Social Security Number 216 27 5335 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 17 Yrs. | | 8. Date of Birth Month Day Year Aug 5 1966 | | 9. Birthplace (State or Foreign) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | | | | | | | | | |
| 10b. County Calvert | | | | | | | | | | |
| 10c. City, Town or Location Lusby | | | | | | | | | | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 10e. Street and Number 11739 Sidewinder Lane | | | | | | | | | | |
| 10f. Zip Code 20657 | | | | | | | | | | |
| 10g. Citizen of What Country? United States | | | | | | | | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | | | | | | | |
| 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | | | | | | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | |
| 14. Race - American Indian, Black, White, etc. Specify: white | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11th | | | | | | | | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) student | | | | | | | | | | |
| 16b. Kind of Business/Industry n/a | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Jeffery Charles Poss | | | | | | | | | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Charlene Kerns | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jeffery C. Poss- father | | | | | | | | | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11739 Sidewinder Lane Lusby, MD 20657 | | | | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Funeral Service | | | | | | | | | | |
| 20c. Location - City or Town, State Alexandria Virginia | | | | | | | | | | |
| 20d. Date April 28 2004 | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee B. Rausch | | | | | | | | | | |
| 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676 | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE INJURIES Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 23d. Date of delivery Month Day Year | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? XX Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year) 4-24-04 | | | | | | | | | | |
| 28b. Time of Injury FOUR 1913M | | | | | | | | | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 28d. Describe how injury occurred DRIVEN OVER AN IMPACT WITH FIXED OBJECTS | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ROADWAY | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) SOLLARS WHARF RD LUSBY MD | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier Meyne Marshall | | | | | | | | | | |
| 29c. License number O.C.M.E | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year) APRIL 25, 2004 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAYNARD B. KOREN 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | | | | | | | | | |
| 32. Registrar's Signature Koren B. Koren | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15043

1- For
State
Registrar

AMEND ITEM #24a PER VERB C831 5/11/04 Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Lewis Reed Sr

2. Date of Death

April 27 2004

3. Time of Death

0325 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

216-22-2036

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
October 30, 1925

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hancock

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9000 Corner Road

10f. Zip Code

21750

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

County Government

17. Father's Name (First, Middle, Last)

James Walter Reed

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Mae Weller

19a. Informant's Name/Relationship (Type, Print)

Venetta H. Reed/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9000 Corner Road Hancock, MD 21750

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Orchard Ridge Cem.

Date

04/30/04

20c. Location - City or Town, State

Hancock, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

141 West Main Street
Grove Funeral Home, P.A. Hancock, MD 21750-036823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Renal Failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

James M. Reed

29c. License number

D 60396

29d. Date signed (Month, Day, Year)

04/27/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARID MURSHED 1126 Opal Court Hag. Md

31. Date filed (Month, Day, Year)

MAY 11 2004

32. Registrar's Signature

B. A. Smith

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No.

2004 15014

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Gary Lee RESH

2. Date of Death

April 21, 2004

3. Time of Death

1430 M

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

214-54-0686

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 8, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

115 Plantation Drive

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: National Guard

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

driver

16b. Kind of Business/Industry

trucking

17. Father's Name (First, Middle, Last)

George H. Resh

18. Mother's Name (First, Middle, Maiden Surname)

Marguerite V. Mills

19a. Informant's Name/Relationship (Type, Print)

Donna Resh - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

115 Plantation Dr., Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Broadfording Mem.Gdns. 4/24/04 Hagerstown, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Scott M. Minner

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E.Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Septicemia

b. Due to (or as a consequence of):

Severe Decubitus Ulcer

c. Due to (or as a consequence of):

Debilitating illness

d. Due to (or as a consequence of):

multiple sclerosis

Approximate Interval Between Onset and Death

19 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

malnutrition

poor Left Ventricular function
cardiomegaly

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Francisco Andrade MD

29c. License number

027898

29d. Date signed (Month, Day, Year)

4/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCISCO ANDRADE 350 MILL ST. HAGERSTOWN MD 21740

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Barbara B. Spade

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Impairment: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Funeral
Director

1- For
State
Registrar

Please Type or Print in Black Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2004 15045

Reg. No.

| | | | | | | | | | |
|--|--|---|--|--|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Thelma Rendina | | | | 2. Date of Death Month April Day 22 Year 2004 | | | | 3. Time of Death 8:30a M | |
| 4a. Facility Name (If not institution, give street and number) 624 Kensington Avenue East | | | | 4b. City, Town, or Location of Death Severna Park | | | | 4c. County of Death Anne Arundel | |
| 5. Social Security Number 272-07-4341 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Apr. 16, 1917 | | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Severna Park | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 624 Kensington Avenue East | | | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Legal Secretary | | | 16b. Kind of Business/Industry Law Firm | | |
| 17. Father's Name (First, Middle, Last) Frederick Elmore Brown | | | | 18. Mother's Name (First, Middle, Maiden Surname) Susan Crabb | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ronald A. Rendina/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 624 Kensington Ave. East Severna Park, MD 21146 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery | | Date April 26, 2004 | | 20c. Location - City or Town, State Glen Burnie, MD | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ischemic Cardiomyopathy Due to (or as a consequence of): Coronary Atherosclerosis Due to (or as a consequence of): 210yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last S/P Coronary Artery Bypass Grafty | | | | | | | | | Approximate Interval Between Onset and Death |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/P Coronary Artery Bypass Grafty | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D0015685 | | 29d. Date signed (Month, Day, Year) 4/23/04 | | | |
| 30. Name and address of person who completed certificate of death (Item 23a) (Type, Print) Allec Schaff MD 3001 S Hanover St Baltimore MD 21225 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | | | 32. Registrar's Signature  | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15046

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Emory Clark Rice, Jr.

2. Date of Death

Month
AprilDay
27Year
2004

3. Time of Death

11:20 AM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

219-28-3410

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 8, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2545 Carrollton Road

10f. Zip Code

21403

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1954-84

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Emory C. Rice, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Svitak

19a. Informant's Name/Relationship (Type, Print)

Ann Rice/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2545 Carrollton Road Annapolis, Maryland 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Trinity Church Cem.

Date

4/30/2004

20c. Location - City or Town, State

Upper Marlboro, MD

21. Signature of Funeral Service Licensee

Todd E. Liller

22. Name and Address of Facility

John M. Taylor Funeral Home
147 Duke of Gloucester Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
7-7 day

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure
cerebral vascular accident

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. T. Liller MD

29c. License number

D-27804

29d. Date signed (Month, Day, Year)

4/28/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert J. Peterson MD

AAMC Annapolis MD 21401

31. Date filed (Month, Day, Year)

APR 29 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15047

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Ann Wilma Rapsinski | | 2. Date of Death Month April Day 15 Year 2004 | | 3. Time of Death 1123p^M | |
| 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| 5. Social Security Number 190-22-7424 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | 8. Date of Birth (Month, Day, Year) 03/02/23 | 9. Birthplace (State or Foreign Country) PA. | |
| Usual Residence of Decedent | | | | | |
| 10a. State PA. | 10b. County Fulton | 10c. City, Town or Location McConnellsburg | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 551 N. Fifth St | | 10f. Zip Code 17233 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 17. Father's Name (First, Middle, Last) William Sutara | | 18. Mother's Name (First, Middle, Maiden Surname) LenaRapusait | | | |
| 19a. Informant's Name/Relationship (Type, Print) Carol Babinsack/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 N Third St. McConnellsburg, Pa. 17233 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Our Lady of Hope Cem, | | 20c. Location - City or Town, State 4/19/04 Tarentum, PA. | |
| 21. Signature of Funeral Service Licensee C. Burner | | 22. Name and Address of Facility Burner Trade Services P.A. 1037 Dual Pl. Hagerstown, Md. 21740 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Acute Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Renal Failure Vascular Disease | | | | | |
| Approximate Interval Between Onset and Death days | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure Vascular Disease | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Karl R. Riggall | | 29c. License number 038764 | | 29d. Date signed (Month, Day, Year) 4/16/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karl R. Riggall, MD 1136 Opel Court Hagerstown MD 21740 | | | | | |
| 31. Date filed (Month, Day, Year) APR 23 2004 | | 32. Registrar's Signature Kevin B. Sparks | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15048

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Keith Brian SAWYERS

2. Date of Death

Month Day Year
APRIL 26 2004

3. Time of Death

2:10A M

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

218-82-3916

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 1 1961

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17952 Garden Lane

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1979-85

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Carroll Sawyers

18. Mother's Name (First, Middle, Maiden Surname)

Beverly Fleishman

19a. Informant's Name/Relationship (Type, Print)

Carroll Sawyers - Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

407 Walton Avenue Baltimore, Maryland 21225

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hagerstown Crematory

Date

4/26/04

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

James R. Seizer

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Abdominal carcinomatosis

Approximate
Interval Between
Onset and Death

4 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Cutaneous malignant melanoma

11 months

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Hind Hamdan, MD

29c. License number

DH6473

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hind Hamdan, MD: 1130 OPAL CT.; Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

James R. Seizer

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15049

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Blanche V. Sweeney

2. Date of Death

Month Day Year
April 25, 2004

3. Time of Death

2045 PM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

216-22-1172

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12-6-1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21140 Woodfield Road

10f. Zip Code

20882

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Photographer

16b. Kind of Business/Industry

NIH

17. Father's Name (First, Middle, Last)

Frank Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Schwartzbeck

19a. Informant's Name/Relationship (Type, Print)

Mary Musser / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14007 E. Annapolis Ct., Mt. Airy, MD 21771

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Pine Grove

Date

04-30-2004

20c. Location - City or Town, State

Mt. Airy, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Olin L. Molesworth, P.A. Funeral Home
26401 Ridge Road, Damascus, MD 20872

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

COPD

Due to (or as a consequence of):

Pulmonary Hypertension

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

BC 1082039

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18109 Prince Philip Drive, Suite 225, Olney, MD 20832

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15050

1- For
State
Registrar

| | | | | | |
|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHARLES EWELL SIMPKINS Jr | | 2. Date of Death Month Day Year April 26, 2004 | | 3. Time of Death 8:15 PM M |
| | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George's |
| Funeral Director | 5. Social Security Number 220-32-5029 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | 8. Date of Birth (Month, Day, Year) July 1, 1939 | 9. Birthplace (State or Foreign Country) Washington, DC |
| | 10a. State Maryland | | 10b. County Charles | | 10c. City, Town or Location Waldorf |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 205 Charmuth Court | | 10f. Zip Code 20602 |
| | 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painting/Wall Covering | | 16b. Kind of Business/Industry Home Improvement | | 17. Father's Name (First, Middle, Last) Charles E. Simpkins Sr |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Dorothy McIntire Simpkins | | 19a. Informant's Name/Relationship (Type, Print) Eleanor L. Simpkins (wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Charmuth Ct. Waldorf, MD 20602 |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens 4-30-04 | | 20c. Location - City or Town, State Waldorf, MD |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee [Signature] M00173 | | 22. Name and Address of Facility Eberwein Funeral Services | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Non Hodgkins Lymphoma Due to (or as a consequence of): Abdominal Aortic Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of): |
| | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number D001923 |
| | 29d. Date signed (Month, Day, Year) April 27, 2004 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T.L. Field's MD Waldorf MD 20601 | | 31. Date filed (Month, Day, Year) APR 30 2004 |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature [Signature] | | 33. State Registrar APR 30 2004 | | 34. State Registrar APR 30 2004 |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15051

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Peter S. Sagisi

2. Date of Death

Month April Day 26 Year 2004

3. Time of Death

2:30 A M

4a. Facility Name (If not institution, give street and number)

157 Island View Drive

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

127-14-2928

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 1, 1911

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

157 Island View Drive

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian - Pacific Islander

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Diplomatic - U.N.

17. Father's Name (First, Middle, Last)

Barnabe Sagisi

18. Mother's Name (First, Middle, Maiden Surname)

Monica Sagisi

19a. Informant's Name/Relationship (Type, Print)

Marina Sagisi Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

157 Island View Drive Annapolis, Maryland 21401

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Memorial

Date

5/1/2004

20c. Location - City or Town, State

Davidsonville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Myocardial Infarction

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death
☐ Pregnant at time of death
☐ Unknown☐ Ectopic pregnancy
☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Goldstein 205 Ridgely Ave Annapolis

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended Box 10C
WCHD/CZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4-22-04
1- For State Registrar Per FH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15052

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Elaine Naomi Shirk | | 2. Date of Death Month Day Year April 20 2004 | | 3. Time of Death 0235 M | |
| 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | 4b. City, Town, or Location of Death Hagerstown, | | 4c. County of Death Washington | |
| 5. Social Security Number 219-20-3017 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | |
| 8. Date of Birth (Month, Day, Year) July 25, 1922 | | 9. Birthplace (State or Foreign Country) MD | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County Washington | | 10c. City, Town or Location Clear Spring, Hagerstown | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 11508 Dellwyn Drive | | 10f. Zip Code 21740 | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) 0 | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | 16b. Kind of Business/Industry residence | | 17. Father's Name (First, Middle, Last) Earl Leon Small | |
| 18. Mother's Name (First, Middle, Maiden Surname) Naomi Hawbaker | | 19a. Informant's Name/Relationship (Type, Print) Robert E. Shirk son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 233 Clear Spring, MD. 21722 | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) April 23, 2004 Little Rose Hill Cem | | 20c. Location - City or Town, State Clear Spring, MD | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc P.O. BOX 310 Clear Spring, MD 21722 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GASTROPARASITIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) M | | 28b. Time of Injury 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28c. Describe how injury occurred | | 28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D 27949 | | 29d. Date signed (Month, Day, Year) April 20 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Hattberg 11110 Medical Campus Rd Hyg. Md | | | | | |
| 31. Date filed (Month, Day, Year) APR 22 2004 | | 32. Registrar's Signature | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Steven J. Schuster

04-2751 1-

For
State
Registrar

State of Maryland / Department of Health and Mental Hygiene
undep item #23a, 27, 28a-f, PER ME, 6831, 5/13/04

Certificate of Death

Reg. No. 2004 15053

Baltimore, Maryland 21215-0036


Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Steven Joseph Schuster | | 2. Date of Death Month Day Year April 21, 2004 | | 3. Time of Death 6:11 P M | |
| 4a. Facility Name (If not institution, give street and number) 5764 Pindell Road | | 4b. City, Town, or Location of Death Lothian | | 4c. County of Death Anne Arundel | |
| 5. Social Security Number 214-02-4661 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 28 Yrs. | 8. Date of Birth (Month, Day, Year) Feb. 6, 1976 | 9. Birthplace (State or Foreign Country) Maryland | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County Anne Arundel Co. | 10c. City, Town or Location Lothian | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 5764 Pindell Road | | 10f. Zip Code 20711 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) Carpenter | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter | | 16b. Kind of Business/Industry Construction Company | | | |
| 17. Father's Name (First, Middle, Last) William Andrews | | | 18. Mother's Name (First, Middle, Maiden Surname) Karen Frances Schuster | | |
| 19a. Informant's Name/Relationship (Type, Print) Karen F. Schuster (Mother) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5764 Pindell Road, Lothian, Maryland 20711 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery | | 20c. Location - City or Town, State Clinton, Maryland | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Narcotic Intoxication Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause or injury that initiated events resulting in death) Last | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) At scene | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 4/21/04 | | 28b. Time of Injury 6:02p M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred unknown | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5764 Pindell Rd, Baltimore, MD | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number O.C.M.E. | |
| 29d. Date signed (Month, Day, Year) April 22, 2004 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15054

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Maxine Ellen Trace

2. Date of Death

April 24, 2004

3. Time of Death

12:45 AM

4a. Facility Name (If not institution, give street and number)

Eden Pines Assisted Living

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

188-12-3743

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 24, 1917

9. Birthplace (State or Foreign Country)

Hagerstown, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1165 Virginia Ave.

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Grocery

17. Father's Name (First, Middle, Last)

Edgar Harold Jones

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Landers

19a. Informant's Name/Relationship (Type, Print)

Glenda Austin / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

210 Mealey Parkway, Hagerstown, MD 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem Gdns

Date

04/28/2004

20c. Location - City or Town, State

Hagerstown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gerald N. Minnich Funeral Home

305 N. Potomac Street, Hagerstown, MD 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Final Stage Dementia

Approximate Interval Between Onset and Death

2m

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) ASSISTED LIVING

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D18019

29d. Date signed (Month, Day, Year)

APRIL 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VASANT DATTA MD 340 MILL ST HAGERSTOWN MD 21740

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15055

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NORMAN CARLISLE THOMPSON

2. Date of Death

Month Day Year
April 22, 2004

3. Time of Death

12:15 AM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

214-03-8673

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept 7 1912

9. Birthplace (State or Foreign Country)

Pleasantville MD

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Knoxville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4121 Weston Drive

10f. Zip Code

21758

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

B&O Railroad
Brunswick, MD

17. Father's Name (First, Middle, Last)

John F. Thompson

18. Mother's Name (First, Middle, Maiden Surname)

Rhoda Agnes Hoffman

19a. Informant's Name/Relationship (Type, Print)

John A. Thompson, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8317 Fawn Heather Court, Las Vegas, Nevada 89129

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mark's Cemetery

Date

4/26/2004

20c. Location - City or Town, State

Petersville, MD

21. Sign here of Funeral Service Licensee

Barbara A. Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home
100 Petersville Road, Brunswick, MD 21716

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Pneumonia

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lynn

29c. License number

D47169

29d. Date signed (Month, Day, Year)

4/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ho, CHAN-KING M.D. 610 9th Ave, Brunswick, MD 21716

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Barbara A. Williams

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15056

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ella M. Tyrrell

2. Date of Death

April 22, 2004

3. Time of Death

1538 M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

22780 Laurel Glen Rd. Unit 107

4b. City, Town, or Location of Death

California

4c. County of Death

St. Mary's

5. Social Security Number

116-09-7867

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 30, 1917

9. Birthplace (State or Foreign Country)

Scotland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

California

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22780 Laurel Glen Rd. Unit 107

10f. Zip Code

20619

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Town Government

17. Father's Name (First, Middle, Last)

James McMillan

18. Mother's Name (First, Middle, Maiden Surname)

Mary McDonald

19a. Informant's Name/Relationship (Type, Print)

Kathleen Tyrrell/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

223 Calvert Drive Lusby, Maryland 20657

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

So. Mem. Gardens

Date

Apr. 26, 04 Dunkirk, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

1451 Dares Beach Rd.
Sewell Funeral Home Prince Fred., MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. STROKE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesterolemia
Advanced Age
COPD

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0058572

29d. Date signed (Month, Day, Year)

April 24, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gwyneth Blattan, MD 110 Hospital Road, Suite 310 Prince Frederick MD 20678

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15057

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)

Brenda Lee Turner

2. Date of Death
Month Day Year

April 24 2004

3. Time of Death

3:25 a^M

4a. Facility Name (If not institution, give street and number)

461 Avon Court

4b. City, Town, or Location of Death

Friendship

4c. County of Death

Anne Arundel

5. Social Security Number

579-84-8184

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

8. Date of Birth (Month, Day, Year)

Oct 21, 1957

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Friendship

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

461 Avon Court

10f. Zip Code

20758

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

registered nurse

16b. Kind of Business/Industry

health care

17. Father's Name (First, Middle, Last)

Roy Temple Lawson

18. Mother's Name (First, Middle, Maiden Surname)

Sadie Virginia Grierson

19a. Informant's Name/Relationship (Type, Print)

Charles E. Turner, Jr., spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

461 Avon Court, Friendship, MD 20758

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

So. Memorial Gardens 4-27-2004

Date

20c. Location - City or Town, State

Dunkirk, MD

21. Signature of Funeral Service Licensee

William R. [Signature]

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cervical cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

two years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Kevin Knopf, M.D.

29c. License number

D 0051301

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin Knopf, M.D. 900 Bestgate Rd., Ste 300, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15058

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward James Vaughn

2. Date of Death

April 24 2004

3. Time of Death

4:10 a^M

4a. Facility Name (If not institution, give street and number)

10700 Ward Road

4b. City, Town, or Location of Death

Dunkirk

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

218-30-8261

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 1, 1934

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Dunkirk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10700 Ward Road

10f. Zip Code

20754

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

automobile mechanic

16b. Kind of Business/Industry

automobile repair

17. Father's Name (First, Middle, Last)

John

Vaughn

18. Mother's Name (First, Middle, Maiden Surname)

Lillie

Rose

19a. Informant's Name/Relationship (Type, Print)

Mabel L. Vaughn, spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10700 Ward Road, Dunkirk, MD 20754

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

4-27-2004

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

William R. Hens

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Advanced squamous cell cancer of face

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Cther:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Arati C. Patel

29c. License number

D59061

29d. Date signed (Month, Day, Year)

4/26/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arati C. Patel, MD 110 Hosp Rd. Ste 111 Prince Frederick MD 20678

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

James B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23c or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15059

1- For
State
Registrar

AMEND ITEM #24a PER PHY G831 5/11/04 JH

Certificate of Death

Reg. No.

| | | | | | | | |
|--|--|---|---|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ruth Elizabeth Wetzel | | | 2. Date of Death Month Day Year April 2 2004 | | 3. Time of Death 5:45P M | |
| | 4a. Facility Name (If not institution, give street and number) Westminster Nursing & Rehabilitative | | | 4b. City, Town, or Location of Death Westminster | | 4c. County of Death Carroll | |
| Funeral Director | 5. Social Security Number 215-10-5420 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) Jul. 6, 1911 |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Carroll | | 10c. City, Town or Location Union Bridge |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 295 Clear Ridge Rd. | | 10f. Zip Code 21791 | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) seamstress | | 16b. Kind of Business/Industry clothing factory | |
| 17. Father's Name (First, Middle, Last) John Elias Welty | | | 18. Mother's Name (First, Middle, Maiden Surname) Oda Belle Lock | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ray E. Wetzel/ son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 295 Clear Ridge Rd. Union Bridge, MD 21791 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Hill Cemetery | | Date 4/5/2004 | | 20c. Location - City or Town, State nr. Woodsboro, MD | |
| 21. Signature of Funeral Service Licensee Catherine O. Hartzler | | 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COPD - Chronic obstructive Pulmonary Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 4-5 | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Meningitis Dementia | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier JH MD | | 29c. License number D33184 | | 29d. Date signed (Month, Day, Year) April 5, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Kushner 114 Business Center Drive Reisterstown, MD | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 06 2004 | | 32. Registrar's Signature Steven B. Spivey | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, 24A

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15060

1- For State Registrar Amend#10e, per FH, 4/30/04, FCHD Certificate of Death SL

Reg. No.

| | | | | | |
|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Betty L. Walker | | 2. Date of Death Month Day Year April 29, 2004 | | 3. Time of Death 3:23A. M |
| | 4a. Facility Name (If not institution, give street and number) Homewood at Crumland Farm | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick |
| Funeral Director | 5. Social Security Number 485-18-1039 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | 8. Date of Birth (Month, Day, Year) April 20, 1923 | 9. Birthplace (State or Foreign Country) Iowa |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Frederick | 10c. City, Town or Location Frederick | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 7407 Willow Road 7407 Williw Road | | 10f. Zip Code 21702 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk | | 16b. Kind of Business/Industry Heavy equipment | | |
| | 17. Father's Name (First, Middle, Last) James Burton Davison | | 18. Mother's Name (First, Middle, Maiden Surname) Winnie Hays | | |
| | 19a. Informant's Name/Relationship (Type, Print) Shirley Jack - Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8208 Virginia Lane, Frederick, Maryland 21704 | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) American Mausoleum | | 20c. Location - City or Town, State Peoria, Illinois |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <i>Sharon Michelle Cline</i> | | 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pneumonia a. Due to (or as a consequence of): Dementia b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 2 days years |
| | 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | | | 23c. Date of delivery Month Day Year |
| | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | | | 23d. Date of delivery Month Day Year |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hairy Cell Leukemia Hypothyroid Hypertension | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29c. License number MDD16428 | | |
| | 29b. Signature and title of certifier <i>Casper E. Cline</i> | | 29d. Date signed (Month, Day, Year) 4/29/04 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Casper E. Cline, II - 300 West Ninth Street, Frederick, Maryland 21701 | | | | |
| 31. Date filed (Month, Day, Year) APR 30 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15061

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

| | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last) ALVIE LEO WILES | | | | 2. Date of Death Month Day Year APRIL 25 2004 | | | | 3. Time of Death 4.50 a M | |
| 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | | | 4b. City, Town, or Location of Death Frederick | | | | 4c. County of Death Frederick | |
| 5. Social Security Number 214-16-0183 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) 2-25-1918 | | 9. Birthplace (State or Foreign Country) Maryland | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Frederick | | 10c. City, Town or Location Frederick | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 902 Young Place | | | | 10f. Zip Code 21702 | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | 16b. Kind of Business/Industry Brush Company | | |
| 17. Father's Name (First, Middle, Last) Alvie Columbus Wiles | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ida Alene Shankle | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Pat Hevner/ Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11419 Handboard Rd., Union Bridge, MD 21719 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Gar. | | Date 4-28-04 | | 20c. Location - City or Town, State Frederick, Maryland | |
| 21. Signature of Funeral Service Licensee <i>Courtesy Mark</i> | | | | 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike Frederick, MD 21702 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease | | | | | | | | | |
| Approximate Interval Between Onset and Death 30 years | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| a. Due to (or as a consequence of): | | | | | | | | | |
| b. Due to (or as a consequence of): | | | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Left Pleural Effusion | | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier <i>J. L. Krantz MD</i> | | | | 29c. License number 20035152 | | | 29d. Date signed (Month, Day, Year) 4/25/04 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. L. Krantz, MD 180 Thos Johnson Dr Frederick, MD 21702 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

7

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15062

1- For State Registrar

Certificate of Death

Reg. No.

| | | | | | |
|---|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sherman Wheeler, Sr | | 2. Date of Death Month Day Year April 25, 2004 | | 3. Time of Death 6:30AM M |
| | 4a. Facility Name (If not institution, give street and number) Clinton Nursing Home and Rehab Ctr. | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George's |
| Funeral Director | 5. Social Security Number 064-03-5455 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 93 Yrs. | 8. Date of Birth (Month, Day, Year) April 27, 1910 | 9. Birthplace (State or Foreign Country) Virginia |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Prince George's | 10c. City, Town or Location Clinton | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 5908 Sellner Lane | | 10f. Zip Code 20735 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance | | 16b. Kind of Business/Industry Hotel Industry | | |
| | 17. Father's Name (First, Middle, Last) Samuel Wheeler | | 18. Mother's Name (First, Middle, Maiden Surname) Lucy Messick | | |
| | 19a. Informant's Name/Relationship (Type, Print) Charles Wheeler (Son) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5908 Sellner Lane Clinton, Maryland 20735 | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maple Grove Cemetery | | 20c. Location - City or Town, State New York City |
| | 21. Signature of Funeral Service Licensee Louis L. Hunt MD00257 | | 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiopulmonary Failure</u> Due to (or as a consequence of): b. <u>Malignant Hypertension</u> Due to (or as a consequence of): c. <u>Parkinson's Disease</u> Due to (or as a consequence of): d. Substantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| 23b. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Organic Brain Syndrome</u> <u>History of Septicemia</u> | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier B... | | 29c. License number D-51520 | |
| 29d. Date signed (Month, Day, Year) 4-23-04 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahran Pishdad MD 1328 Southern Avenue SE Washington DC #310 20032 | | | |
| 31. Date filed (Month, Day, Year) APR 30 2004 | | 32. Registrar's Signature ... | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15063

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stewart W. Wilderson

2. Date of Death

Month Day Year
April 24 2004

3. Time of Death

12:20A^M

4a. Facility Name (If not institution, give street and number)

Holy Cross Rehab

4b. City, Town, or Location of Death

Burtonsville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

216 03 3991

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 29, 1910 Maryland

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6084 Old Washington Road

10f. Zip Code

21075

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Gunther
Brewing Company

17. Father's Name (First, Middle, Last)

Horace B. Wilderson

18. Mother's Name (First, Middle, Maiden Surname)

Maude Ford

19a. Informant's Name/Relationship (Type, Print)

Midge Bryant/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5270 Morning Mist Lane Alexandria VA 22312

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Meadowridge Cem. 4/27/2004 Elkridge, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M01044

22. Name and Address of Facility

Harry H. Witzke's Family FH
4112 Old Columbia Pike Ellicott City, MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Chronic Renal Failure

Due to (or as a consequence of):

b. Diabetes Mellitus

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

6 months

5 yrs.

5 yrs.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Pending
investigation
3 ☐ Accident 4 ☐ Suicide
5 ☐ Could not be
determined
6 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0053615

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Anna Nathan 1125 Rockville Pike #1 208 Rockville MD 20852

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Kean S. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

penn. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar
AMEND# 24a,26
4/28/04 Per Phy. QMH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15064

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Elizabeth E. Wells

2. Date of Death

Month Day Year
April 8 2004

3. Time of Death

12:20 M

4a. Facility Name (If not institution, give street and number)

1175 Madison Street Apt. A1

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

218-30-6710

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 19 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1175 Madison Street Apt. A1

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Cleaning

17. Father's Name (First, Middle, Last)

Eugene Baden

18. Mother's Name (First, Middle, Maiden Surname)

Laura Betters

19a. Informant's Name/Relationship (Type, Print)

Patricia Foote (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

53 Juliana Circle East Annapolis, Md. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bessiegate Memorial

Park

Date

4/14/04

20c. Location - City or Town, State

Annapolis, Md.

21. Signature of Funeral Service Licensee

Larry H. Reese M00485

22. Name and Address of Facility

Wm. Reese & Sons Mortuary, P.A.
821 West St. Annapolis, Md. 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

probable myocardial infarction

b. Due to (or as a consequence of):

atrial fibrillation

c. Due to (or as a consequence of):

Diabetes

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure, HTN, hx colon CA
hypercholesterol.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Signature and title of certifier
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29c. License number

H60239

29d. Date signed (Month, Day, Year)

4/12/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2002 Medical Parkway - Sajak Ste 670, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2058.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Craig Walden
04-02763
RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15065

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Craig Michael Walden

2. Date of Death
Month Day Year

April 22, 2004

3. Time of Death
M

0847 A

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

216-13-0425

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

32

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Aug. 4, 1971

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert Co.

10c. City, Town or Location

Chesapeake Beach

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8072 Silver Fox Way

10f. Zip Code

20732

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Marketing Representative

16b. Kind of Business/Industry

Pastry Company

17. Father's Name (First, Middle, Last)

Ronald H. Walden

18. Mother's Name (First, Middle, Maiden Surname)

Mary Lou Metsch

19a. Informant's Name/Relationship (Type, Print)

Ronald Barry Walden (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3140 Drawfield Lane, Huntingtown, MD 20639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lakemont Mem. Gardens

Date

April 27,
2004

20c. Location - City or Town, State

Davidsonville, Maryland

21. Signature of Funeral Service Licensee

Michael W. Lee

22. Name and Address of Facility

Lee Funeral Home Calvert, P.A.
8125 Southern Maryland Blvd., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Head and abdominal injuries

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an
autopsy
performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available
prior to completion of cause of
death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical
examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury
(Month, Day Year)

April 22, 2004

28b. Time of
Injury

7:41 M

28c. Injury at
Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

driver in collision with tree

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

roadway

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

Rt 2, Sunderland, MD

29a. Certifier
(Check only
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tasha Z Greenberg MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tasha Z Greenberg M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Karen B. Spiller

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15066

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Barbara Lawrence Wilson

2. Date of Death

April 26 2004

3. Time of Death

2 A M

4a. Facility Name (If not institution, give street and number)

Solomons Nursing Center

4b. City, Town, or Location of Death

Solomons

4c. County of Death

Calvert

5. Social Security Number

013 07 0601

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

86

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept 13 1917

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Lusby

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13370 Joy Road

10f. Zip Code

20657

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Revlon Corporation

16b. Kind of Business/Industry

Business consultant

17. Father's Name (First, Middle, Last)

Marino Antonio Nobili Lawrence

18. Mother's Name (First, Middle, Maiden Surname)

Grace Ella Putnam

19a. Informant's Name/Relationship (Type, Print)

William Norman Wilson- husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13370 Joy Road Lusby Maryland 20657

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Funeral Service

Date

April 26 2004

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

B. Rausch

22. Name and Address of Facility

Rausch Funeral Home PA
4405 Broomes Is. rd. Port Republic MD 2067623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CVA

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

- a. Due to (or as a consequence of):
Arrival Fibrillation
- b. Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d.

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. J. Taylor

29c. License number

097610

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Tardio MD Prince Frederick MD 20678

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Beverly K. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15067

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES ATKINS

2. Date of Death

April 27, 2004

3. Time of Death

2128 M

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

225-30-2630

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 16, 1927

9. Birthplace (State or Foreign Country)

unk

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

272 S. Broadway

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

unk

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:

unk

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4or 5+)

unk

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

unk

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Sinai Hospital

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2401 W. Belvedere Avenue Baltimore, MD 21215

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) in state20b. Place of Disposition (Name of
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Arrhythmia

Due to (or as a consequence of):

b. ASCVD

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Mass

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. Ahmed MD

29c. License number

D39127

29d. Date signed (Month, Day, Year)

5/4/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821 N. Eutaw St Baltimore MD 21201

DR. A. AHMED MD

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Beverly B. Spence

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15068

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM ALLEN

2. Date of Death

Month
04Day
29Year
04

3. Time of Death

3:23 AM

4a. Facility Name (If not institution, give street and number)

FOREST GLEN NURSING HOME

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

237-34-5102

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)
Jan. 5, 1925

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Bladensburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5999 Emerson Street, #525

10f. Zip Code

20710

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1943

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Ernest Allen

18. Mother's Name (First, Middle, Maiden Surname)

Eva Mae Allen

19a. Informant's Name/Relationship (Type, Print)

Bessie L. Allen - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5999 Emerson St., #525 Bladensburg, MD 20710

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery

Date

5/07/04

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

Ralph Williams

22. Name and Address of Facility

Latney's Funeral Home, Inc.
3831 Georgia Ave., NW, Washington, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Stage III B Gastric Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

b. H/o Colon Cancer 20 years ago

Due to (or as a consequence of):

20 yrs. ago

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Type II Diabetes mellitus

Due to (or as a consequence of):

Unknown

d. Hypertension

Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

anemia

Cardio-respiratory failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Charles D. M.D.

29c. License number

D43121

29d. Date signed (Month, Day, Year)

05/05/04

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NURUL CHOWDHURY, MD; 5141 KING CHARLES WAY; BETHESDA, MD 20814

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1. For State Registrar

State of Maryland / Department of Health and Mental Hygiene
 Amend Item 23a per Dr. G831, 05/12/04 dnb

Certificate of Death

Reg. No. 2004 15069

| | | | | | | | | | | | |
|---|---|-------------|---|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Carolyn L. Allison | | | | | | 2. Date of Death Month Day Year April 14, 2004 | | 3. Time of Death 8:10 AM M | | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | | 4c. County of Death Anne Arundel | | | |
| Funeral Director | 5. Social Security Number 216-20-6177 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept 24, 1927 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 806 Washburn Avenue | | | | 10f. Zip Code 21225 | | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) assembler | | | 16b. Kind of Business/Industry factory | | | | |
| 17. Father's Name (First, Middle, Last) John Goellner | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Louise Weiland | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Sherry Prada/friend | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Audrey Avenue Baltimore, Md 21225 | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal failure Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 24 hr. | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | | | 23d. Date of delivery Month Day Year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23a. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 26. Place of Death (Check only one) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Nancy F. Snow | | | | 29c. License number H0053369 | | 29d. Date signed (Month, Day, Year) 4/14/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANCY F. SNOW, MD, Anne Arundel Med. Ctr. | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | 32. Registrar's Signature Benjamin S. Sparks | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15070

1- For State Registrar

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Mary Lee Beacham

2. Date of Death

May 4, 2004

3. Time of Death

1130 A M

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

210-24-9735

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 30, 1932

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1 Brett Court #221

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

disabled

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

George Shannon Evans

18. Mother's Name (First, Middle, Maiden Surname)

Mary Viola Lee

19a. Informant's Name/Relationship (Type, Print)

Karen Lusby/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17 National Drive Baltimore, MD 21221

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension; Diabetes mellitus;
Coronary artery disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Pending investigation
3 ☒ Accident 4 ☐ Suicide 5 ☐ Could not be determined
6 ☐ Homicide

28a. Date of Injury (Month, Day Year)

unk

28b. Time of Injury

unk M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject fell

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

unk

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Unknown

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

R. Carls

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Allen Locke, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15071

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joan Anna Bokker

2. Date of Death
Month Day Year

April 29, 2004

3. Time of Death

7:05 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

215-30-8866

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

May 20, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6672 Roberts Court

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

waitress

16b. Kind of Business/Industry

restaurant

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

18. Mother's Name (First, Middle, Maiden Surname)

Angeles Kvech

19a. Informant's Name/Relationship (Type, Print)

Johanna Showers/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

507 Kent Circle NE Glen Burnie, MD 21060

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

ESSENTIAL HYPERTENSION

Due to (or as a consequence of):

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 MONTH

25 YEARS

8 YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PSORIASIS

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

H. H. H. M.D.

29c. License number

D14160

29d. Date signed (Month, Day, Year)

APRIL 30, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARVEY SINGH M.D. 110-A RITCHIE HIGHWAY
BALTIMORE, MARYLAND 21225State
Registrar

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

B. B. B.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2004 15072

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) Beatrice M. Bradyhouse
2. Date of Death Month Day Year May 09 2004
3. Time of Death 5:30 am

Funeral Director

4a. Facility Name (If not institution, give street and number) Joseph Ritchie House
4b. City, Town, or Location of Death Baltimore
4c. County of Death N/A

5. Social Security Number 213-20-9362
6. Sex 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday) 80 Yrs.
8. Date of Birth (Month, Day, Year) Oct. 23, 1923
9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent
10a. State Md.
10b. County Baltimore
10c. City, Town or Location Catonsville
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 715 Maiden Choice Lane
10f. Zip Code 21228
10g. Citizen of What Country? USA

11. Marital Status 1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk
16b. Kind of Business/Industry Typist

17. Father's Name (First, Middle, Last) Richard G. Bradyhouse, Jr.
18. Mother's Name (First, Middle, Maiden Surname) Ethel E. Parlett

19a. Informant's Name/Relationship (Type, Print) Mr. Jeffrey F. Higdon/ Attorney
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 York Rd. Suite 110 Lutherville, Md. 21093

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cem.
Date 5-13-04
20c. Location - City or Town, State Baltimore, Md.

21. Signature of Funeral Service Licensee
22. Name and Address of Facility Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) BREAST CANCER
Approximate Interval Between Onset and Death YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last
a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death 1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number D29071
29d. Date signed (Month, Day, Year) 5/10/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. ANANDA KRISHNAN 824 N. EUNTAW ST BALTIMORE MD 21201

31. Date filed (Month, Day, Year) MAY 12 2004
32. Registrar's Signature

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15073

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William S. Brucker

2. Date of Death

Month

Day

Year

May 9, 2004

3. Time of Death

12:30 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

215-12-8567

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec. 24, 1922

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1500 Providence Road

10f. Zip Code

21286

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No WW II

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Engineering

17. Father's Name (First, Middle, Last)

Frederick L. Brucker

18. Mother's Name (First, Middle, Maiden Surname)

Anna F. Spiers

19a. Informant's Name/Relationship (Type, Print)

Beulah Brucker/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1500 Providence Road Towson, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Svc. Corp.

Date

05/10/2004

20c. Location - City or Town, State

Towson, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ESOPHAGEAL CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):

d. _____

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)HOSPICE

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

5/10/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

State
Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MAY 9, 2004 12:30 a.m.

Baltimore, Maryland 21215-0020

WILLIAM BRUCKER

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No.

2004 15074

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sister M. Gerald Blakeley O.S.F.

2. Date of Death

Month Day Year
MAY 8, 2004

3. Time of Death

4:00 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

207-40-8603

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Oct 28 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7601 Osler Drive

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Berlin Blakeley

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Marie Smyth

19a. Informant's Name/Relationship (Type, Print)

Sister Margaret St. John

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7601 Osler Dr. Towson, Md. 21204

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Our Lady Of Angel Cem. 5-11-04

Date

20c. Location - City or Town, State

Aston, Pa.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

ABDOMINAL AORTIC ANEURYSM

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D30263

29d. Date signed (Month, Day, Year)

05-08-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Robyn Lynn Baginski

04-03044

RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15075

1- For
State
Registrar

Unpend Item #23a&27 per me G854 8/3/04 las

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|--|--|--|--|-------------------------------|--|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robyn Lynn Baginski | | | | 2. Date of Death Month Day Year May 4, 2004 | | | | 3. Time of Death 1010 P.M. | | | | | |
| | 4a. Facility Name (If not institution, give street and number) St. Agnes Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | | | | |
| Funeral Director | 5. Social Security Number 213-64-8305 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 49 Yrs. | | 8. Date of Birth (Month, Day, Year) May 20, 1954 | | 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Catonsville | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| | 10e. Street and Number 24 1/2 Dunvegan Road | | | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? United States | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nursing | | 16b. Kind of Business/Industry Health Care Provider | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Francis A. Martin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ida K. Reese | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Bandorick /Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 373 Cool Breeze Ct. Pasadena, MD 21122 | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Cemetery | | Date 5/7/2004 | | 20c. Location - City or Town, State Marriottsville, MD | | | | | | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | | | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Seizure disorder</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) May 5, 2004 | |
| | 29b. Signature and title of certifier | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. A. R. Cook, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15076

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>William L. Beverley Jr.</u> | | 2. Date of Death Month <u>May</u> Day <u>5</u> Year <u>2004</u> | | 3. Time of Death <u>6:11 P M</u> |
| | 4a. Facility Name (If not institution, give street and number) <u>Baltimore VA Medical Center</u> | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>N/A</u> |
| Funeral Director | 5. Social Security Number <u>212-44-3418</u> | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>57</u> Yrs. | 8. Date of Birth (Month, Day, Year) <u>Sept. 6, 1946</u> | |
| | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State <u>M.D.</u> | | 10b. County <u>N/A</u> |
| | 10c. City, Town or Location <u>Baltimore</u> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number <u>2314 W. Lanvale Street</u> | | 10f. Zip Code <u>21217</u> | | 10g. Citizen of What Country? <u>U.S.A.</u> |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: <u>Black</u> | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Foreman</u> | | 16b. Kind of Business/Industry <u>Armco Steel Company</u> |
| | 17. Father's Name (First, Middle, Last) <u>William Lindsay Beverley, Sr.</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Lois Branch</u> | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>Lois M. Beverley- Mother</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1206 Myrtle Avenue, Balto., M.D. 21217</u> | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Garrison Forest</u> | | 20c. Location - City or Town, State <u>5/12/2004 Owings Mills, M.D.</u> |
| | 21. Signature of Funeral Service Licensee <u>[Signature]</u> | | 22. Name and Address of Facility <u>Nutter Funeral Home Inc. 2501 Gwynnsfalls Pkwy, Balto., M.D. 21216</u> | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Pneumonia</u> | | | | Approximate Interval Between Onset and Death |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| | a. Due to (or as a consequence of): | | | | |
| | b. Due to (or as a consequence of): | | | | |
| | c. Due to (or as a consequence of): | | | | |
| | d. Due to (or as a consequence of): | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown |
| | 23d. Date of delivery Month Day Year | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Obstructive Pulmonary Disease</u> <u>Squamous cell carcinoma of the neck</u> | | | | 23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) <u>M</u> | | 28b. Time of Injury <u>1</u> Yes <input type="checkbox"/> No | |
| 28c. Describe how injury occurred | | 28d. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <u>[Signature] MD</u> | | 29c. License number <u>P17650</u> | |
| 29d. Date signed (Month, Day, Year) <u>5-5-4</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Brian Salter, MD 10 N Greene Street + Baltimore, MD 21201</u> | | | |
| 31. Date filed (Month, Day, Year) <u>MAY 12 2004</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15077

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

| | | | | | | | | | | | | | | |
|--|---|--|---|-------------------------------|---|--|--|--|--|--|--|--|-------------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Valerie Jane Barron | | | | | | | | | | 2. Date of Death Month Day Year May 7 2004 | | 3. Time of Death 2:00 p M | |
| | 4a. Facility Name (If not institution, give street and number) Futurecare - Chesapeake | | | | | | | | | | 4b. City, Town, or Location of Death Arnold | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 059-10-4827 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 27, 1917 | | 9. Birthplace (State or Foreign Country) Massachusetts | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Arnold | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| | 10e. Street and Number 606 Oakland Hills Drive, Apt. 202 | | | | | | 10f. Zip Code 21012 | | 10g. Citizen of What Country? USA | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | | | | |
| | 17. Father's Name (First, Middle, Last) Amedee Demaris | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edith Jane Ward | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) James W. Barron, Sr. (Husband) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 Oakland Hills Dr., Apt. 202, Arnold, MD 21012 | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 5-10-2004 | | 20c. Location - City or Town, State Baltimore, MD | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute myocardial infarction hours Due to (or as a consequence of): b. hypertension years Due to (or as a consequence of): c. diabetes mellitus years Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | | | | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) | | | | | |
| 23d. Date of delivery Month Day Year | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia recent urinary tract infection | | | | | | | | | | | | | | |
| 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | | 29c. License number 041955 | | 29d. Date signed (Month, Day, Year) 5-7-04 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rebecca E. Barron MD 8601 Veterans Highway #204 Millersville MD 21108 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | 32. Registrar's Signature | | | | | | | | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15078

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Aleene Pollard Brewer

2. Date of Death
Month Day Year

May 7 2004 12:12 p M

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Kris Leigh Assisted Living

4b. City, Town, or Location of Death

Gambrills

4c. County of Death

Anne Arundel

5. Social Security Number

577-24-4632

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Oct. 19, 1921

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2011 Aberdeen Drive

10f. Zip Code

21114

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Food Service Provider

16b. Kind of Business/Industry

County Schools

17. Father's Name (First, Middle, Last)

William O. Pollard

18. Mother's Name (First, Middle, Maiden Surname)

Rose M. Evans

19a. Informant's Name/Relationship (Type, Print)

Marth Evans (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Bendingwood Circle, Taylors, SC 29687

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

National Mem. Park

Date

5/10/2004

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

Bald A

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, condition, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Assisted

Living

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Russell R. Deluca, MD

29c. License number

031551

29d. Date signed (Month, Day, Year)

May 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Russell R. Deluca, MD, 305 Hospital Drive, Olney, MD 21061

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Bald A

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15079

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Maxwell L. Baron

2. Date of Death

May 8 2004

3. Time of Death

10:45A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

BALTIMORE

5. Social Security Number

277-03-7959

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-10-1913

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3704 N. Charles St.

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white.

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

BALTIMORE
DISPLAY INDUSTRY

17. Father's Name (First, Middle, Last)

Charles Baron.

18. Mother's Name (First, Middle, Maiden Surname)

Rose Baron.

19a. Informant's Name/Relationship (Type, Print)

Julie Cahan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

344 Homeland Southway, Baltimore, MD 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVALS FUNERAL CHAPEL 5-10-04 Forest Hill, MD

Date

20c. Location - City or Town, State

MD 21093

21. Signature of Funeral Service Licensee

Kimberly L. Zurek

22. Name and Address of Facility

2325 YORK RD, TIMONIUM CENTER
PEACEFUL ALTERNATIVES FUNERAL & CREMATION

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. recurrent aspiration pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. oropharyngeal dysphagia

Due to (or as a consequence of):

weeks

c. multiple strokes

Due to (or as a consequence of):

weeks

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic renal failure

prostate cancer

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. A. Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

MAY 8, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley G BMC 6701 N. Charles St. Balts. md 21204

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Benjamin A. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15080

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GRACIE B. BARNES

2. Date of Death

May 8, 2004

3. Time of Death

9:27 P M

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

241-68-3848

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10-7-1923

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2654 PARK HEIGHTS TERRACE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

-12-

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

PARENTING

16b. Kind of Business/Industry

FOSTERCARE

17. Father's Name (First, Middle, Last)

JAMES B. WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

CHANNIE NORRIS

19a. Informant's Name/Relationship (Type, Print)

HAZEL C. BARNES (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4228 PIMLICO RD. BALTIMORE, MARYLAND 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VETERANS

Date

5-17-2004

20c. Location - City or Town, State

OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee

Jonathan D. Hibner

Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jonathan D. Hibner

29c. License number

D0058910

29d. Date signed (Month, Day, Year)

May 8, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leah Wendell MD, Sinai Hospital, 2401 W. Belvedere Ave., Baltimore, MD

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

James B. Barnes

State
Registrar

Gracie B. Barnes

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15081

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lillie

Barnes

2. Date of Death

Month
MayDay
9Year
2004

3. Time of Death

908 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

241-64-5569

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

November 30, 1939

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4784 Shamrock Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

Church Hospital

17. Father's Name (First, Middle, Last)

Richard Harris

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Moore

19a. Informant's Name/Relationship (Type, Print)

Janet Harris/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4784 Shamrock Avenue Baltimore MD 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial PK 5-14-04

Date

20c. Location - City or Town, State

Arbutus, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Harris P. Close Funeral Service, P.A.
709 Tessier St., Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unknown

unknown

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure, Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

Medical Resident

29c. License number

RES000

29d. Date signed (Month, Day, Year)

May 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allison Dilks 4940 Eastern Avenue, Baltimore MD 21224

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

Amend & Unpenditem #1,23a,27 per me G831 5/13/04 las

Certificate of Death

Reg. No.

2004 15082

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Benny Benjamin Brown III

2. Date of Death

May 5, 2004

3. Time of Death

2205 p^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

2701 W. Lauretta Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

220-38-5057

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

5-26-1944

9. Birthplace (State or Foreign

Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes ☐ No

10e. Street and Number

2701 Lauretta Avenue

10f. Zip Code

21223

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11th gradeCollege (1-4or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Post Office

17. Father's Name (First, Middle, Last)

Benny Benjamin Brown, II

18. Mother's Name (First, Middle, Maiden Surname)

Louise Owens

19a. Informant's Name/Relationship (Type, Print)

Naomi Brown - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1631 Stonewood Road Balto, Md 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King Memorial Park

Date

5/11/2004

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Balto, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Hypertensive atherosclerotic cardiovascular disease

Approximate
Interval Between
Onset and DeathSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene


27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

OCME

29d. Date signed (Month, Day, Year)

May 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACK M. TITUS MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15083

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Doris E. Cooper | | 2. Date of Death Month Day Year April 28, 2004 | | 3. Time of Death 1:50 PM M |
| | 4a. Facility Name (If not institution, give street and number) 5504 Sycamore Avenue | | 4b. City, Town, or Location of Death Arbutus | | 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number 215-14-5997 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | 8. Date of Birth (Month, Day, Year) Mar 24, 1923 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Baltimore | 10c. City, Town or Location Arbutus | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 5504 Sycamore Avenue | | 10f. Zip Code 21227 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) secretary | | 16b. Kind of Business/Industry insurance bonding | | |
| | 17. Father's Name (First, Middle, Last) Harry Frederick Engles | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Ethel Hunt | | |
| | 19a. Informant's Name/Relationship (Type, Print) Sandra Siffrin/daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5504 Sycamore Avenue Arbutus, MD 21227 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Tasneem Lakhtani | | 29c. License number D28595 | | 29d. Date signed (Month, Day, Year) 5/6/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TASNEEM LAKHTANI, 7220 PARK HEIGHTS AVE BALD MD 21208 | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature [Signature] | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15084

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph G. Crawson

2. Date of Death

May 10, 2004

3. Time of Death

11:53 P M

4a. Facility Name (If not institution, give street and number)

346 Shetlands Square

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

228-36-6834

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 30, 1933

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

346 Shetlands Square

10f. Zip Code

21061

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: Korean Conflict

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director of Special Olympics

16b. Kind of Business/Industry

Montgomery County

17. Father's Name (First, Middle, Last)

Edward Ellis Crowson

18. Mother's Name (First, Middle, Maiden Surname)

Audra Collins

19a. Informant's Name/Relationship (Type, Print)

Robert E. Crawson/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

119 Crosstimber Way, Frederick, Maryland 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

May 14, 2004

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

M00689

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue,
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Albin Kuhn M.D.

29c. License number

D21336

29d. Date signed (Month, Day, Year)

May 11, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Albin Kuhn, M.D. 8028 Ritchie Highway, Pasadena, Maryland 21122

31. Date filled (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No. 2004 15085

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMILY COLE

2. Date of Death

Month
MAYDay
11Year
2004

3. Time of Death

12:10 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

215-70-6051

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 9, 1958

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Woodlawn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7428 Catterick Court

10f. Zip Code

21244

10g. Citizen of What Country?

U. SA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Radiologist

16b. Kind of Business/Industry

Mercy Medical Center

17. Father's Name (First, Middle, Last)

Elmer Wright

18. Mother's Name (First, Middle, Maiden Surname)

EVA Richardson

19a. Informant's Name/Relationship (Type, Print)

Reginald M. Cole Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7428 Catterick Ct, Woodlawn, MD 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery MAY 15, 04 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald A. Grayson

22. Name and Address of Facility

Ronald A. Grayson Funeral Home 108 West North Ave, Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

b. MULTIPLE SCLEROSIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ronald A. Grayson

29c. License number

D54352

29d. Date signed (Month, Day, Year)

MAY 11 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIRCEA TOSOR NORTHWEST HOSPITAL 5401 OLD COURT ROAD RANDALLSTOWN MD 21133

State
Registrar

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Ronald A. Grayson

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 24e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15086

1- For
State
Registrar

| | | | | | | | | | | | |
|---|--|---|---|--|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Louis James Citro | | | | 2. Date of Death Month Day Year May 7 2004 | | | | 3. Time of Death 9:08 P M | | |
| | 4a. Facility Name (If not institution, give street and number) 4321 Soth Avenue | | | | 4b. City, Town, or Location of Death Baltimore County | | | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 219 01 6236 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) September 24 1921 | | 9. Birthplace (State or Foreign Country) Baltimore, Maryland | | |
| | 10a. State Maryland | | | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore County | | | | |
| To Be Completed by Funeral Director | 10e. Street and Number 4321 Soth Avenue | | | | 10f. Zip Code 21236 | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Offset Press Leader | | | 16b. Kind of Business/Industry Social Security Administrat. | | | |
| | 17. Father's Name (First, Middle, Last) Joseph Citro | | | | 18. Mother's Name (First, Middle, Maiden Surname) Theresa Vito | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Allison Citro (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9805 Magledt Road Baltimore, Maryland 21234 | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery | | Date May 11 2004 | | 20c. Location - City or Town, State Baltimore, Maryland | | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC ADENOCARCINOMA - UNKNOWN PRIMARY MONTHS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D40480 | | 29d. Date signed (Month, Day, Year) May 10, 2004 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERNANDO FERRO, MD | | | | | | 7672 Belair Rd. Baltimore, MD 21236 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15087

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Richard O. Catron

2. Date of Death
Month Day Year
May 10, 2004

3. Time of Death
3:45 P M

Funeral Director

4a. Facility Name (If not institution, give street and number)

Montgomery Hospice-Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

215-38-6498

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 8, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

620 Monroe Street

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)
-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Director

16b. Kind of Business/Industry

University

17. Father's Name (First, Middle, Last)

Owen B. Catron

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Gollehan

19a. Informant's Name/Relationship (Type, Print)

Deirdre D. Martin/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

524 Musket Court, Collegeville, PA 19426

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

May 14, 2004

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

M00689

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Lung Cancer metastatic to the Brain

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

over 3 Mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41218

29d. Date signed (Month, Day, Year)

5/10/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Harrison, M.D., 6001 Muncaster Mill Road, Rockville, MD 20855

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15088

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward W. Cox

2. Date of Death
Month Day Year

May 4, 2004

3. Time of Death

11:35 PM^M

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

220-58-8147

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

January 29, 1954

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11121 Newport Mill Road

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Puerto Rican

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Officer

16b. Kind of Business/Industry

Security

17. Father's Name (First, Middle, Last)

Robert R. Cox

18. Mother's Name (First, Middle, Maiden Surname)

Maria I. Rosich

19a. Informant's Name/Relationship (Type, Print)

Maria I. Cox/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11121 Newport Mill Road Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

May 11, 2004

20c. Location - City or Town, State

Bronx, New York

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M Means-Markwell

29c. License number

M54722

29d. Date signed (Month, Day, Year)

May 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Means-Markwell, M.D. 8600 Old Georgetown Road Bethesda, Maryland 20814

31. Date filed (Month, Day, Year)

MAY 12 2004

Registrar's Signature

Beyna B Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 15089

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Edward Francis Clagett

2. Date of Death

Month Day Year
May 9, 2004

3. Time of Death

4:30 PM

4a. Facility Name (If not institution, give street and number)

18405 Gardenia Way

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

263-80-8841

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 26, 1947

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18405 Gardenia Way

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Francis Gilbert Clagett

18. Mother's Name (First, Middle, Maiden Surname)

Ita Anne Willard

19a. Informant's Name/Relationship (Type, Print)

Catharine H. Clagett/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18405 Gardenia Way, Gaithersburg, Maryland 20879

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Potomac United
Methodist Church Cemetery

Date

May 13,
2004

20c. Location - City or Town, State

Potomac, Maryland

21. Signature of Funeral Service Licensee

M01346

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

Diabetes Mellitus Type II

Sleep Apnea

24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D35370

29d. Date signed (Month, Day, Year)

May 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jan Bachowski, M.D. 11125 Rockville Pike, Rockville, Maryland 20852

State
Registrar

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

Certificate of Death

Reg. No. 2004 15090

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Remaner Cole | | | | 2. Date of Death Month May Day 7 Year 2004 | | 3. Time of Death 8:37 AM | |
| | 4a. Facility Name (If not institution, give street and number) Harbor Hospital Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 220-22-5324 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) 12/15/1917 | |
| | 9. Birthplace (State or Foreign Country) North Carolina | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3034 Southland Avenue | | 10f. Zip Code 21225 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Homemaker | | | |
| | 17. Father's Name (First, Middle, Last) Ben Ramsey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Julian Bass | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Robert R. Coles /Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209 5806 Western Run Drive Apt. B, Baltimore, Maryland | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Nat'l Ceme. | | 20c. Location - City or Town, State Catonsville, Maryland | | 20d. Date 05/13/2004 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Cardiac Ischemia Due to (or as a consequence of): c. Coronary Artery Disease Due to (or as a consequence of): d. Non-insulin dependent diabetes mellitus | | | | Approximate Interval Between Onset and Death 2 hours 7 hours 20 years 40 years | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | |
| | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| | 29b. Signature and title of certifier Gerald Apollon M.D. | | | | 29c. License number D37874 | | 29d. Date signed (Month, Day, Year) May 7, 2004 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerald Apollon M.D. 3001 South Hanover Street, Baltimore | | | | 31. Date filed (Month, Day, Year) MAY 12 2004 | | | |
| | 32. Registrar's Signature | | | | 33. Date of Death May 7, 2004 | | | |

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 15091

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rose CITESTER

2. Date of Death

Month

Day

Year

05

10

2004

3. Time of Death

1:45 P M

4a. Facility Name (If not institution, give street and number)

Riverview Nursing Home

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-01-4792

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

February 19, 1911

9. Birthplace (State or Foreign Country)

VA.

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6604 North Point Road

10f. Zip Code

21219

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas Podruchny

18. Mother's Name (First, Middle, Maiden Surname)

Viola Tompanko

19a. Informant's Name/Relationship (Type, Print)

Benjamin Chester

son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2919 Wells Avenue, Edgemere, MD. 21219

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Trinity Russian Orth.

Date

May 14, 2004

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Heart disease.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Hypercholesterolemia

Due to (or as a consequence of):

d. Ischemic Cardiomyopathy

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

gastrointestinal bleeding

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sebastian John O

29c. License number

0055171

29d. Date signed (Month, Day, Year)

05/10/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3023 Eastern Avenue, Baltimore, MD 21224.

State
Registrar

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Benjamin A Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15092

Certificate of Death

Reg. No.

1- For
State
Registrar

| | | | | | |
|---|---|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MANUEL COONIN | | 2. Date of Death Month MAY Day 9 Year 2004 | | 3. Time of Death 6:00 P M |
| | 4a. Facility Name (If not institution, give street and number) 12325 FALLS ROAD | | 4b. City, Town, or Location of Death COCKEYSVILLE | | 4c. County of Death BALTIMORE |
| Funeral Director | 5. Social Security Number 216-05-4947 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) JUNE 12, 1918 | | 9. Birthplace (State or Foreign Country) MD | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State MD | | 10b. County BALTIMORE |
| | 10c. City, Town or Location COCKEYSVILLE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 12325 FALLS ROAD | | 10f. Zip Code 21030 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary 12 College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK | | 16b. Kind of Business/Industry MARYLAND JOCKEY CLUB | | |
| | 17. Father's Name (First, Middle, Last) ABE KUNIN | | 18. Mother's Name (First, Middle, Maiden Surname) MOLLIE GELLER | | |
| | 19a. Informant's Name/Relationship (Type, Print) BLANCHE COONIN / WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7524 SEVEN MILE LANE - BALTIMORE, MD 21208 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ANSHE EMUNAH (AITZ CHAIM) | | 20c. Location - City or Town, State BALTIMORE, MD |
| | 21. Signature of Funeral Service Licensee <i>Michael Berger</i> | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE | | | | Approximate Interval Between Onset and Death |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ARTERIOSCLEROTIC HEART DISEASE | | | | 25 YEARS |
| | ATRIAL FIBRILLATION | | | | 10 YEARS |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown |
| | 23d. Date of delivery Month Day Year | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Bernard Ryan</i> | | 29c. License number D 22115 | 29d. Date signed (Month, Day, Year) 7/10/2004 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERNARD RYAN, MD, 8600 LIBERTY RD. RANALSTOWN, MD 21131 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature <i>Sparks</i> | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15093

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Margarete Bierwes Deranger | | | | 2. Date of Death Month Day Year May 8, 2004 | | 3. Time of Death 6:20P M | |
| 4a. Facility Name (If not institution, give street and number) Genesis Heritage Meridian Center | | | | 4b. City, Town, or Location of Death Dundalk | | 4c. County of Death Baltimore Co. | |
| 5. Social Security Number 464-48-7338 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) March 30, 1920 | |
| 9. Birthplace (State or Foreign Country) Germany | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 8400 Kavanagh Road | | | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> +2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Teacher | | 16b. Kind of Business/Industry Education | |
| 17. Father's Name (First, Middle, Last) Hubertus Bierwes | | | | 18. Mother's Name (First, Middle, Maiden Surname) Antoinette Jung | | | |
| 19a. Informant's Name/Relationship (Type, Print) Andrew Deranger (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6459 Summer Cloud Way Columbia, Maryland 21045 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus | | Date 5/11/2004 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee Stephanie Mass | | | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC BREAST CANCER Due to (or as a consequence of): ANEMIA Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Sevinde K Jelle MD | | 29c. License number D 27188 | | 29d. Date signed (Month, Day, Year) 5/10/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sevinde K Jelle 2 Market Place Dundalk MD 21222 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | 32. Registrar's Signature Sevinde K Jelle | | | |

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15094

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Alan Dickey

2. Date of Death

Month Day Year
May 9, 2004

3. Time of Death

3:35 A^M

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

286-14-8209

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 13, 1915

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State
Maryland10b. County
Montgomery10c. City, Town or Location
Garrett Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10715 Weymouth Street

10f. Zip Code

20896

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cost Analyst

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Malcolm Dickey

18. Mother's Name (First, Middle, Maiden Surname)

Grace Thome

19a. Informant's Name/Relationship (Type, Print)

Robert B. Dickey/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 64, Garrett Park, Maryland 20896

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Grandview Cemetery

Date

May 15, 2004

20c. Location - City or Town, State

Chillicothe, Ohio

21. Signature of Funeral Service Licensee

M00689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Cancer of the Bladder

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D38457

29d. Date signed (Month, Day, Year)

May 9, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nakul Goyal, M.D. 3801 International Drive, #211, Silver Spring, MD 20906-1550

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15095

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Rose M. Dimick | | 2. Date of Death Month May Day 9 Year 2004 | | 3. Time of Death 6:04 P M | |
| 4a. Facility Name (If not institution, give street and number) 3728 Fait Avenue | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| 5. Social Security Number 214-03-4262 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 88 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) November 1, 1915 |
| 9. Birthplace (State or Foreign Country) MD. | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD. | 10b. County N/A | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 3728 Fait Avenue | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Housewife | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) Vito Ruggiero | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Tartaglia | | |
| 19a. Informant's Name/Relationship (Type, Print) George J. Dimick son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7300 Kirtley Road, Baltimore, Md. 21224 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | 20c. Location - City or Town, State May 13, 2004 Dundalk, MD. | |
| 21. Signature of Funeral Service Licensee Anthony C. Connelly | | 22. Name and Address of Facility Connolly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of): b. emphysema Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death ten years | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | | | | |
| 23d. Date of delivery Month Day Year | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Rooney Brooks | | 29c. License number 043636 | | 29d. Date signed (Month, Day, Year) May 10, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3120 Erdman Avenue Baltimore, Maryland 21213 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature Beverly B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **AMEND ITEM # 7 PER FH G831 5/12/04** **Certificate of Death**

Reg. No.

2004 15096

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) ZELMAN | | 2. Date of Death Month MAY Day 9 Year 2004 | | 3. Time of Death 5:55 P M | |
| 4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT CENTER | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 216-37-6786 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | 8. Date of Birth (Month, Day, Year) DEC. 26, 1919 | 9. Birthplace (State or Foreign Country) UKRAINE | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County BALTIMORE | 10c. City, Town or Location PIKESVILLE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 16 OLD COURT ROAD #520 | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? UKRAINE | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER | | 16b. Kind of Business/Industry ELECTRICAL | | | |
| 17. Father's Name (First, Middle, Last) MOSES DUKSTANSKIY | | | 18. Mother's Name (First, Middle, Maiden Surname) HANAH DINERHALTER | | |
| 19a. Informant's Name/Relationship (Type, Print) SARRA PERELMAN / WIFE | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 OLD COURT ROAD #520 - PIKESVILLE, MD 21208 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW CEM. | | 20c. Location - City or Town, State REISTERSTOWN, MD | |
| 21. Signature of Funeral Service Licensee <i>Michael Bruger</i> | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S DISEASE Approximate Interval Between Onset and Death 1 YEAR | | | | | |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | | |
| 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Dr. Sunshine, MD</i> | | 29c. License number DIS140 | | 29d. Date signed (Month, Day, Year) MAY 10, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SUNSHINE, MD 6210 PK H5 AVE, BALD MD 2145 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature <i>Benjamin B. Sparks</i> | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend Item 18 per Md. Code, § 10-107, 10/12/04
State of Maryland, Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2004 15097

| | | | | | |
|---|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Georgia Davis | | 2. Date of Death Month 5 Day 1 Year 2004 | | 3. Time of Death 4:10p M |
| | 4a. Facility Name (If not institution, give street and number) 2318 Druid Park Drive | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA |
| Funeral Director | 5. Social Security Number 217-34-9501 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | 8. Date of Birth (Month, Day, Year) 02 14 38 | |
| | 9. Birthplace (State or Foreign Country) VA | | Usual Residence of Decedent | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County NA | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 2318 Druid Park Drive | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) na | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse | | 16b. Kind of Business/Industry Private Duty | | |
| | 17. Father's Name (First, Middle, Last) Roosevelt Pettigrew | | 18. Mother's Name (First, Middle, Maiden Surname) Bertha Jenkins Berth Jenkins | | |
| | 19a. Informant's Name/Relationship (Type, Print) Nelson Pettigrew-Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2318 Druid Park Drive, Baltimore Md 21215 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. 5/6/04 Baltimore, Md | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Baltimore, Md. 21215 March F.H. West 4300 Wabash Ave. | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Generalised Carcinomatosis | | | | Approximate Interval Between Onset and Death 2 weeks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last metastatic cancer of colon | | | | 2 months | |
| | | | | Adenocarcinoma Colon 4 years | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> MD | | 29c. License number D 45274 | | 29d. Date signed (Month, Day, Year) 5/6/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cho Namgy, MD. 516 N Rolling Rd #204, Catonsville, MD 21228 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15098

1- For
State
Registrar

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>WAVERLY DRUMMOND</u> | | | | 2. Date of Death Month <u>MAY</u> Day <u>8</u> Year <u>2004</u> | | 3. Time of Death <u>4:26 P.M.</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>HARFORD GARDENS NURSING HOME</u> | | | | 4b. City, Town, or Location of Death <u>BALTIMORE</u> | | 4c. County of Death <u>N/A</u> | |
| Funeral Director | 5. Social Security Number <u>231 46 0277</u> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>67</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>JULY 15, 1936</u> | |
| | 9. Birthplace (State or Foreign Country) <u>MARYLAND</u> | | 10a. State <u>MD</u> | | 10b. County <u>N/A</u> | | 10c. City, Town or Location <u>BALTIMORE</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number <u>4700 HARFORD ROAD</u> | | 10f. Zip Code <u>21214</u> | | 10g. Citizen of What Country? <u>U.S.A</u> | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u> | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) <u>7TH</u> Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>LABORER</u> | | 16b. Kind of Business/Industry <u>CONSTRUCTION</u> | | 17. Father's Name (First, Middle, Last) <u>MATTHEW DRUMMOND</u> | |
| | 18. Mother's Name (First, Middle, Maiden Surname) <u>MACIE BUTTS</u> | | 19a. Informant's Name/Relationship (Type, Print) <u>ORIS DRUMMOND</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4920 HOGANS LAKE PL ANNANDALE, VA. 22003</u> | | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| Physician /Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>GOOD HOPE CHURCH CFM. MAY 15, 2004 BLACKRIDGE VA</u> | | 20c. Location - City or Town, State <u>BLACKRIDGE VA</u> | | 21. Signature of Funeral Service Licensee <u>Calvin B. Scruggs</u> | | 22. Name and Address of Facility <u>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST BALTO, MD 21213</u> | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>A.S.E.U.D.</u> | | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23d. Date of delivery Month Day Year | | 23e. Date of delivery Month Day Year | | 23f. Date of delivery Month Day Year | | 23g. Date of delivery Month Day Year | |
| | 23h. Date of delivery Month Day Year | | 23i. Date of delivery Month Day Year | | 23j. Date of delivery Month Day Year | | 23k. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23l. Date of delivery Month Day Year | | 23m. Date of delivery Month Day Year | | 23n. Date of delivery Month Day Year | | 23o. Date of delivery Month Day Year | |
| | 23p. Date of delivery Month Day Year | | 23q. Date of delivery Month Day Year | | 23r. Date of delivery Month Day Year | | 23s. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23t. Date of delivery Month Day Year | | 23u. Date of delivery Month Day Year | | 23v. Date of delivery Month Day Year | | 23w. Date of delivery Month Day Year | |
| | 23x. Date of delivery Month Day Year | | 23y. Date of delivery Month Day Year | | 23z. Date of delivery Month Day Year | | 23aa. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23ab. Date of delivery Month Day Year | | 23ac. Date of delivery Month Day Year | | 23ad. Date of delivery Month Day Year | | 23ae. Date of delivery Month Day Year | |
| | 23af. Date of delivery Month Day Year | | 23ag. Date of delivery Month Day Year | | 23ah. Date of delivery Month Day Year | | 23ai. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23aj. Date of delivery Month Day Year | | 23ak. Date of delivery Month Day Year | | 23al. Date of delivery Month Day Year | | 23am. Date of delivery Month Day Year | |
| | 23an. Date of delivery Month Day Year | | 23ao. Date of delivery Month Day Year | | 23ap. Date of delivery Month Day Year | | 23aq. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23ar. Date of delivery Month Day Year | | 23as. Date of delivery Month Day Year | | 23at. Date of delivery Month Day Year | | 23au. Date of delivery Month Day Year | |
| | 23av. Date of delivery Month Day Year | | 23aw. Date of delivery Month Day Year | | 23ax. Date of delivery Month Day Year | | 23ay. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23az. Date of delivery Month Day Year | | 23ba. Date of delivery Month Day Year | | 23bb. Date of delivery Month Day Year | | 23bc. Date of delivery Month Day Year | |
| | 23bd. Date of delivery Month Day Year | | 23be. Date of delivery Month Day Year | | 23bf. Date of delivery Month Day Year | | 23bg. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23bh. Date of delivery Month Day Year | | 23bi. Date of delivery Month Day Year | | 23bj. Date of delivery Month Day Year | | 23bk. Date of delivery Month Day Year | |
| | 23bl. Date of delivery Month Day Year | | 23bm. Date of delivery Month Day Year | | 23bn. Date of delivery Month Day Year | | 23bo. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23bp. Date of delivery Month Day Year | | 23bq. Date of delivery Month Day Year | | 23br. Date of delivery Month Day Year | | 23bs. Date of delivery Month Day Year | |
| | 23bt. Date of delivery Month Day Year | | 23bu. Date of delivery Month Day Year | | 23bv. Date of delivery Month Day Year | | 23bw. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23bx. Date of delivery Month Day Year | | 23by. Date of delivery Month Day Year | | 23bz. Date of delivery Month Day Year | | 23ca. Date of delivery Month Day Year | |
| | 23cb. Date of delivery Month Day Year | | 23cc. Date of delivery Month Day Year | | 23cd. Date of delivery Month Day Year | | 23ce. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23cf. Date of delivery Month Day Year | | 23cg. Date of delivery Month Day Year | | 23ch. Date of delivery Month Day Year | | 23ci. Date of delivery Month Day Year | |
| | 23cj. Date of delivery Month Day Year | | 23ck. Date of delivery Month Day Year | | 23cl. Date of delivery Month Day Year | | 23cm. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23cn. Date of delivery Month Day Year | | 23co. Date of delivery Month Day Year | | 23cp. Date of delivery Month Day Year | | 23cq. Date of delivery Month Day Year | |
| | 23cr. Date of delivery Month Day Year | | 23cs. Date of delivery Month Day Year | | 23ct. Date of delivery Month Day Year | | 23cu. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23cv. Date of delivery Month Day Year | | 23cw. Date of delivery Month Day Year | | 23cx. Date of delivery Month Day Year | | 23cy. Date of delivery Month Day Year | |
| | 23cz. Date of delivery Month Day Year | | 23da. Date of delivery Month Day Year | | 23db. Date of delivery Month Day Year | | 23dc. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23dd. Date of delivery Month Day Year | | 23de. Date of delivery Month Day Year | | 23df. Date of delivery Month Day Year | | 23dg. Date of delivery Month Day Year | |
| | 23dh. Date of delivery Month Day Year | | 23di. Date of delivery Month Day Year | | 23dj. Date of delivery Month Day Year | | 23dk. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23dl. Date of delivery Month Day Year | | 23dm. Date of delivery Month Day Year | | 23dn. Date of delivery Month Day Year | | 23do. Date of delivery Month Day Year | |
| | 23dp. Date of delivery Month Day Year | | 23dq. Date of delivery Month Day Year | | 23dr. Date of delivery Month Day Year | | 23ds. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23dt. Date of delivery Month Day Year | | 23du. Date of delivery Month Day Year | | 23dv. Date of delivery Month Day Year | | 23dw. Date of delivery Month Day Year | |
| | 23dx. Date of delivery Month Day Year | | 23dy. Date of delivery Month Day Year | | 23dz. Date of delivery Month Day Year | | 23ea. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23eb. Date of delivery Month Day Year | | 23ec. Date of delivery Month Day Year | | 23ed. Date of delivery Month Day Year | | 23ee. Date of delivery Month Day Year | |
| | 23ef. Date of delivery Month Day Year | | 23ef. Date of delivery Month Day Year | | 23ef. Date of delivery Month Day Year | | 23ef. Date of delivery Month Day Year | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15099

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

YOLANDA CLAIRE ENGLAND

2. Date of Death

Month Day Year
May 8, 2004

3. Time of Death

8:55P.^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

13410 Arbor Drive

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

126-16-8505

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
April 6, 1927

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13410 Arbor Drive

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Quality Control

16b. Kind of Business/Industry

Aircraft Manufacture

17. Father's Name (First, Middle, Last)

George C. Goldman

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Jaller

19a. Informant's Name/Relationship (Type, Print)

Andy Weiner Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12401 Bent Tree Lane, Minnetonka, MN 55305

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Adath Eshurun Cemetery

Date

05-11-04

20c. Location - City or Town, State

Rdina, Minnesota

21. Signature of Funeral Service Licensee

R. Noel Brady

22. Name and Address of Facility

Andrew K. Coffman Funeral Home, Inc.

40 East Antietam Street, Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Approximate
Interval Between
Onset and Death16 months
3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederic H. Kass III, 11110 Medical Campus Road, Hagerstown, Md.

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15100

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last) ORVILLE E. FARRINGTON | | 2. Date of Death Month Day Year May 5, 2004 | | 3. Time of Death 12:55PM | |
| 4a. Facility Name (If not institution, give street and number) 210 Nantucket Drive | | 4b. City, Town, or Location of Death Port Deposit | | 4c. County of Death Cecil | |
| 5. Social Security Number 239-38-2525 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 72 Yrs. | 8. Date of Birth (Month, Day, Year) 11/11/1931 | | 9. Birthplace (State or Foreign Country) North Carolina |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County cecil | 10c. City, Town or Location Port Deposit | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 210 Nantucket Drive | | 10f. Zip Code 21904 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Construction | | | |
| 17. Father's Name (First, Middle, Last) John Farrington | | | 18. Mother's Name (First, Middle, Maiden Surname) Vertie Barnes | | |
| 19a. Informant's Name/Relationship (Type, Print) carrie Mae Farrington-wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Nantucket Dr., Port Deposit, MD | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Bridge Baptist Cem. | | |
| 20c. Date 5/8/2004 | | | 20d. Location - City or Town, State Colora, MD | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | 22. Name and Address of Facility Harkins F.H.Inc., 600 Main St., Delta, PA 17314 | | |
| 23a. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer | | | | | |
| Approximate Interval Between Onset and Death 1 year | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | | |
| 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> , M.D. | | 29c. License number D0047813 | | 29d. Date signed (Month, Day, Year) May 6, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Bashar Kara Kash, 520 Upper Chesapeake Dr., Bel Air, MD | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15101

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES

FARMER

2. Date of Death

Month Day Year
MAY 10 2004

3. Time of Death

5:01A M

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital Baltimore City

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-82-0855

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 3, 1965

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

DE

10b. County

SUSSEX

10c. City, Town or Location

GEORGETOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18984 Dupont Blvd.

10f. Zip Code

19947

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Elevator Mechanic

16b. Kind of Business/Industry

Elevator Engineering

17. Father's Name (First, Middle, Last)

George James Farmer, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Ruth N. Trott

19a. Informant's Name/Relationship (Type, Print)

Cindy Farmer wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3635 Hernwood Road Woodstock, MD 21163

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Granite Church Cemetery May 14, 2004 Granite, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James B. Cunningham

22. Name and Address of Facility

Burrier-Queen Funeral Crematory, PA
1212 W. Old Liberty Road Winfield MD 21784

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SPINAL ABSCESS

Due to (or as a consequence of):

2 WEEKS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OBESITY, RESPIRATORY FAILURE.
SPINAL PARALYSIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Emily Schnopick MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MAY 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EMILY SCHOPICK, JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

James B. Cunningham

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No.

2004 15102

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard A. Freeman

2. Date of Death

Month Day Year
May 9 2004

3. Time of Death

10:35 a^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

2605 Chapel Lake Dr., #406

4b. City, Town, or Location of Death

Gambrills

4c. County of Death

Anne Arundel

5. Social Security Number

107-14-3557

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 19, 1919

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Gambrills

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2605 Chapel Lake Dr., #406

10f. Zip Code

21054

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Frozen Foods

17. Father's Name (First, Middle, Last)

Richard A. Freeman

18. Mother's Name (First, Middle, Maiden Surname)

Marie Alexander

19a. Informant's Name/Relationship (Type, Print)

Julia H. Freeman (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2605 Chapel Lake Dr., #406, Gambrills, MD 21054

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Cemetery

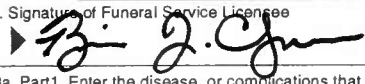
Date

5/12/2004

20c. Location - City or Town, State

Annapolis, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hardesty Funeral Home P.A.
12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):
Left Hemiplegia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
Diabetes Mellitusc. Due to (or as a consequence of):
Hyperlipidemia

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 months

40 yrs.

20+ yrs.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (Specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

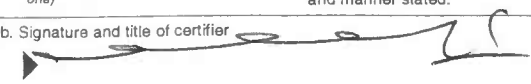
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D14136

29d. Date signed (Month, Day, Year)

5/11/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DALETT S. SAW HNEY Suite 610 Crain Towers Glen Burnie Md 21061

State
Registrar

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature



Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15103

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William J. Ford

2. Date of Death

Month Day Year
May 6 2004

3. Time of Death

2:32 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Upper Chesapeake Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

171-24-4030

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept 6 1930

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Jarrettsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3133 Sharon Rd.

10f. Zip Code

21084

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

pipe fitter

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

William Ford

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Graffious

19a. Informant's Name/Relationship (Type, Print)

C. Rose Ford - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3133 Sharon Rd. Jarrettsville, MD 21084

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem.

Date

May 10 2004

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

Kendra Wells

22. Name and Address of Facility

EVANS Funeral Chapel
3 Newport Dr Forest Hill MD 21050

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cor Pulmonale, right-sided heart failure

Due to (or as a consequence of):

years

c. Congestive heart failure

Due to (or as a consequence of):

years

d. Coronary heart disease

Due to (or as a consequence of):

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Albert S. Sun, M.D.

29c. License number

D 0018779

29d. Date signed (Month, Day, Year)

May 6, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALBERT S. SUN, M.D. 1716 Harford Road Ste. 105 Fallston MD 21047

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Ford, William 031540

5/6/04 1432

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15104

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William H. Garrison

2. Date of Death

May 09 2004

3. Time of Death

12:20 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

225-96-7569

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 23, 1957

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2845 Chesterfield Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Pianist

16b. Kind of Business/Industry

Music

17. Father's Name (First, Middle, Last)

Warren W. Garrison

18. Mother's Name (First, Middle, Maiden Surname)

Jane E. Stinson

19a. Informant's Name/Relationship (Type, Print)

Jenifer T. Garrison / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2845 Chesterfield Avenue; Baltimore, MD 21213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hilltop Service Corp. 5/17/04

Date

20c. Location - City or Town, State

Towson, MD

21. Signature of Funeral Service Licensee

Peter O. O'Leary

22. Name and Address of Facility

Ruck Towson Funeral Home

1050 York Road

Towson, MD 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Multi System Organ Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 day

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Respiratory Failure

Due to (or as a consequence of):

1 day

c. Bronchitis

Due to (or as a consequence of):

7 months

d. Lung Cancer

7 months

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Chelsia Varner, MD

29c. License number

AT 24 38946-D18

29d. Date signed (Month, Day, Year)

May 09, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chelsia Varner, MD 201 East University Parkway, Baltimore MD 21218-2895

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Beverly S. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15105

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|---|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) Marlyn Ann Graber | | 2. Date of Death Month Day Year May 6 2004 | | 3. Time of Death 0200am | |
| 4a. Facility Name (If not institution, give street and number) Stella Maris @ Mercy Hopice Center | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A |
| 5. Social Security Number 218-28-8481 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 41 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 19, 1933 |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Colgate | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number 8030 Gough Street | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Years | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) William Frederick Smith | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Elizabeth Warnecke | | |
| 19a. Informant's Name/Relationship (Type, Print) Anthony J. Graber, Jr. / Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505-02 Eastview Terrace Abingdon, MD 21009 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | Date 5/8/2004 | 20c. Location - City or Town, State Baltimore, Maryland |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>metastatic osteosarcoma</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>hospice</u> | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D40854 | | 29d. Date signed (Month, Day, Year) 5/6/2004 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David Riseberg 301 ST. PAUL PL Baltimore md 21202 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature  | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15106

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ASHLEY JEAN GARLITZ

2. Date of Death

Month Day Year
May 1, 2004

3. Time of Death

0852 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Alleghany

5. Social Security Number

233-11-2855

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

28 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 20, 1975

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1012 Trenum Drive

10f. Zip Code

26726

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 1/2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

David E. Harr, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Yvonne J. Keplinger

19a. Informant's Name/Relationship (Type, Print)

Jeremy S. Garlitz/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1012 Trenum Drive Keyser, WV 26726

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Potomac Memorial Gardens

Date

May 7

20c. Location - City or Town, State

Keyser, WV

21. Signature of Funeral Service Licensee

Brian F. Smith

22. Name and Address of Facility

Smith Funeral Home

85 S. Main Street Keyser, WV 26726

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Multiple injuries

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)
4/30/04

28b. Time of Injury

21:47 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Passenger of motor cycle struck & car

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Route 220 at Bayberry Keyser, West Virginia

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Zakiullah Ali

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 2, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAKIULLAH ALI

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Brian F. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 15107

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) **Marguerite C. Givens** 2. Date of Death Month **May** Day **9** Year **2004** 3. Time of Death **8:14 PM**

4a. Facility Name (If not institution, give street and number) **Montgomery Hospice Casey House** 4b. City, Town, or Location of Death **Rockville** 4c. County of Death **Montgomery**

5. Social Security Number **143-01-6519** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **85** Yrs. 8. Date of Birth (Month, Day, Year) **Oct. 9, 1918** 9. Birthplace (State or Foreign Country) **New Jersey**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Montgomery** 10c. City, Town or Location **Bethesda** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **5322 Wakefield Road** 10f. Zip Code **20816** 10g. Citizen of What Country? **United States**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12)** **College (1-4 or 5+)** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Clerk** 16b. Kind of Business/Industry **Library**

17. Father's Name (First, Middle, Last) **William Hoefling** 18. Mother's Name (First, Middle, Maiden Surname) **Ann Cavanaugh**

19a. Informant's Name/Relationship (Type, Print) **Jean Denney/Daughter** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **5322 Wakefield Road, Bethesda, Maryland 20816**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **St. Gertrude Cemetery** Date **May 17, 2004** 20c. Location - City or Town, State **Colonia, New Jersey**

21. Signature of Funeral Service Licensee **[Signature]** M00198 22. Name and Address of Facility **Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Alzheimer's Disease** Approximate Interval Between Onset and Death **Years**

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (disease or injury) that initiated events resulting in death) Last **a. Due to (or as a consequence of):** **b. Due to (or as a consequence of):** **c. Due to (or as a consequence of):** **d. Due to (or as a consequence of):**

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐ Yes ☒ No ☐ Unknown 23c. If yes, outcome of pregnancy ☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy ☐ Pregnant at time of death ☐ Other (specify) ☐ Unknown 23d. Date of delivery Month **May** Day **17** Year **2004**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **Congestive Heart Failure** 23e. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

Status Post Coronary Artery By-Pass Graft 24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) **Hospice**

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **[Signature]** 29c. License number **D09470** 29d. Date signed (Month, Day, Year) **May 10, 2004**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Eugene P. Libre, M.D. 10400 Connecticut Avenue, Kensington, Maryland 20895**

31. Date filed (Month, Day, Year) **MAY 12 2004** 32. Registrar's Signature **[Signature]**

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15108

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM

GARRISON

2. Date of Death

Month
MAY

Day

08, 2004

3. Time of Death

8:45 A. M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF FOREST HILL

4b. City, Town, or Location of Death

FOREST HILL

4c. County of Death

HARFORD

5. Social Security Number

217-18-6551

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 16, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1600 Samantha Ct.

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

—

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Credit manager

16b. Kind of Business/Industry

Carroll Independent Fuel

17. Father's Name (First, Middle, Last)

FIRMAN GARRISON

18. Mother's Name (First, Middle, Maiden Surname)

Laura Kohlenberg

19a. Informant's Name/Relationship (Type, Print)

Virginia G. Garrison - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1600 Samantha Ct. Forest Hill MD 21050

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVANS FUNERAL CHAPEL

Date

May 11, 2004

20c. Location - City or Town, State

Forest Hill MD

21. Signature of Funeral Service Licensee

Heather Wells

22. Name and Address of Facility

EVANS FUNERAL CHAPEL
3 Newport Dr. Forest Hill MD 21050

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Lymphoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Few years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Emphysema Left Lung

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Manuel Lazatin

29c. License number

D19583

29d. Date signed (Month, Day, Year)

May 8, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MANUEL LAZATIN - 8 LAW STREET - ABERDEEN, MD. 21001

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Sandra B. Sparks

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15109

1- For State Registrar

| | | | | | | | | | | | | |
|---|---|---|---|--|--|--|--|---|-----------------------------|--|--|--|
| Physician / Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rolf H. Hertsgaard | | | 2. Date of Death Month Day Year April 30, 2004 | | 3. Time of Death 11:45 PM | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Oakcrest Village | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | | | | | | |
| Funeral Director | 5. Social Security Number 470-18-4490 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 12, 1922 | 9. Birthplace (State or Foreign Country) Minnesota | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Baltimore | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 10e. Street and Number 8810 Walther Blvd #1514 | | | 10f. Zip Code 21236 | | 10g. Citizen of What Country? USA | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) news broadcaster | | 16b. Kind of Business/Industry journalism | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Oscar I. Hertsgaard | | | 18. Mother's Name (First, Middle, Maiden Surname) Lajla E. Skartvedt | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Holly Hertsgaard/daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2823 Bird View Road Westminster, MD 21157 | | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | | | | | | | |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Congestive Heart Failure</td> <td rowspan="4"> Due to (or as a consequence of): b. ASCVD c. d. </td> </tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> </table> | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Congestive Heart Failure | Due to (or as a consequence of): b. ASCVD c. d. | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Congestive Heart Failure | Due to (or as a consequence of): b. ASCVD c. d. | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier Willie M. Russell | | | 29c. License number D30182 | | 29d. Date signed (Month, Day, Year) May 1 2004 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willie M. Russell MD 8800 W. Altemus Rd Baltimore MD 21234 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 1 2 2004 | | 32. Registrar's Signature Benjamin S. Sparks | | | | | | | | | | |

Rolf Hertsgaard 4/30/04
Baltimore, Maryland 21215-0036 @ 11:45pm

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15110

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louise E. Hock

2. Date of Death

Month Day Year

5 11 04

3. Time of Death

1:15 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Edenwald Care Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

212-18-7568

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 9, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

800 Southerly Road

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Professor

16b. Kind of Business/Industry

New York University

17. Father's Name (First, Middle, Last)

John Hock

18. Mother's Name (First, Middle, Maiden Surname)

Lulu House

19a. Informant's Name/Relationship (Type, Print)

John J. Sweeney, Jr. / attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2525 Pot Springs Road K-408; Timonium, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Baltimore Cemetery

Date

5/15/04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ruck Towson Funeral Home

1050 York Road

Towson, MD 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. PAIRU DUNIA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 hr

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. PAIRU DUNIA

Due to (or as a consequence of):

10 yr.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 27838

29d. Date signed (Month, Day, Year)

May 11, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN SHAVINS, D.O. 518 CAMP MONTANA RD; LUTHER, MD 21096

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

State
Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Louise Hock
Baltimore, Maryland 21215-0036

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15111

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jay Bloss III Holbrook

2. Date of Death

05 03 04

3. Time of Death

5:45 PM

4a. Facility Name (If not institution, give street and number)

Baltimore Rehabilitation Extended Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-30-1292

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 17, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7400 Old Battle Grove Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Jay B. Holbrook, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Maxine Latham

19a. Informant's Name/Relationship (Type, Print)

Matthew A. Hornung / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7402 Old Battle Grove Road Dundalk, MD 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery 5/7/2004

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Den C. Canell

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Brain metastases

Due to (or as a consequence of):

b. Squamous cell skin carcinoma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

4 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John S. Lah, M.D.

29c. License number

34359 (OHIO)

29d. Date signed (Month, Day, Year)

5 3 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John S. Lah, M.D. 3900 Loch Raven Boulevard, Baltimore, Maryland 21218

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 15112

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Alice Anderson Harmon | | | | 2. Date of Death Month Day Year May 9 2004 | | 3. Time of Death 1:08 P M | |
| | 4a. Facility Name (If not institution, give street and number) 1017 Back Bay Beach Road | | | | 4b. City, Town, or Location of Death West River | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 577-24-1038 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) January 22, 1923 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location West River | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1017 Back Bay Beach Road | | 10f. Zip Code 20778 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contract Specialist | | 16b. Kind of Business/Industry Federal Government | | 17. Father's Name (First, Middle, Last) Gerhard T. Anderson | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Edith Stultz | | 19a. Informant's Name/Relationship (Type, Print) Alan J. Harmon / Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1325 Harmony Lane, Annapolis, Maryland 21401-5718 | | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. | | 20c. Location - City or Town, State Bethesda, Maryland | | 21. Signature of Funeral Service Licensee M01305 | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Lymphoma</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number 00051301 | | 29d. Date signed (Month, Day, Year) May 10, 2004 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenne E Kraft MD 900 Bestgate Road Suite 300 Annapolis, MD 21401 | | 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature [Signature] | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15113

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen M. Hyde

2. Date of Death

May 9, 2004

3. Time of Death

3:35 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Long View Nursing Home

4b. City, Town, or Location of Death

Manchester

4c. County of Death

Carroll Co.

5. Social Security Number

216-24-3974

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 7, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll Co.

10c. City, Town or Location

Manchester

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3306 Kennington Square

10f. Zip Code

21102

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

AT+T

17. Father's Name (First, Middle, Last)

James Herbert Howard

18. Mother's Name (First, Middle, Maiden Sumame)

Rena Marie Peterson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Sharon M. Howdyshell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3403 View Ridge Cir. Manchester, MD. 21102

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gar.

Date

May 12, 2004

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

Jeffrey J. Gair, Jr.

22. Name and Address of Facility

Peaceful Alternatives Funeral + Cremation Ctr. 2325 York Rd. Timonium, MD. 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Non Small Cell Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death 9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GERD, AAA, CAD, S, PCABG, HTN

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Pansuriya MD

29c. License number

D 51705

29d. Date signed (Month, Day, Year)

5-10-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURIYA 349 Malcolm Dr, Westminster, MD 21157

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Selma B. Apant

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15114

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THELMA MARIE HOFFMAN

2. Date of Death

Month Day Year MAY 9, 2004 7:55P M

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

214-12-2248

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

AUGUST 26, 1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8820 WALTHER BLVD, APT 4210

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

LOYOLA HIGH SCHOOL

17. Father's Name (First, Middle, Last)

DAVID H. H. SITHAUGHNESSY

18. Mother's Name (First, Middle, Maiden Surname)

MARIE KOPPS

19a. Informant's Name/Relationship (Type, Print)

GEORGE H. HOFFMAN / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8820 WALTHER BLVD APT 4210 PARKVILLE, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)GARRISON FOREST
VETERANS CEMETERY

Date

MAY 17, '04

20c. Location - City or Town, State

GARRISON, MARYLAND

21. Signature of Funeral Service Licensee

Kimberly J. Zorotian

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES
8800 HARFORD RD, PARKVILLE, MD 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ACUTE DIVERTICULITIS

Due to (or as a consequence of):

b. LEFT HYDRONEPHROSIS

Due to (or as a consequence of):

c. ANEMIA

Due to (or as a consequence of):

d. PREVIOUS CEREBROVASCULAR ACCIDENT

Approximate
Interval Between
Onset and Death

DAYS

DAYS

YEARS

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Ceballos, MD

29c. License number

D 25886

29d. Date signed (Month, Day, Year)

May-10-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LILIA CEBALLOS M.D., 7601 OSLER DRIVE TOWSON MARYLAND 21204

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15115

1- For
State
Registrar

| | | | | | |
|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Michele R. HUFF | | 2. Date of Death Month Day Year May 7 2004 | | 3. Time of Death 2:30 AM |
| | 4a. Facility Name (If not institution, give street and number) Joseph Ritchie Hospice | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 219-88-1983 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 39 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) February 24, 1965 | | 9. Birthplace (State or Foreign Country) MD | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State MD | | 10b. County N/A |
| | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 10 Gemini Court | | 10f. Zip Code 21237 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical | | 16b. Kind of Business/Industry Business | | |
| | 17. Father's Name (First, Middle, Last) John Edward HUFF, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Brenda Carey | | |
| | 19a. Informant's Name/Relationship (Type, Print) Novene In's HUFF/Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Gemini Court, Rosedale MD 21237 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Catholic 5/14/04 | | 20c. Location - City or Town, State Baltimore, MD |
| | 21. Signature of Funeral Service Licentiate [Signature] | | 22. Name and Address of Facility Harri P. Close Funeral Service, P.A. 709 Tessier St., Baltimore, MD 21201 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acquired immune deficiency syndrome | | | | Approximate Interval Between Onset and Death > 10 years |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): | | | | |
| | c. Due to (or as a consequence of): | | | | |
| | d. Due to (or as a consequence of): | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier E. Tso MD | | 29c. License number D24170 | | 29d. Date signed (Month, Day, Year) May 7, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Tso MD Richey Hospice 838 N. Entaw St Baltimore MD 21201 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature [Signature] | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15116

1- For State Register AMEND ITEM #19a PER FH G832 6/02/04 JH

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) ELMER A HICKS | | | | | | 2. Date of Death Month MAY Day 5th Year 2004 | | 3. Time of Death 4:55 AM | |
| 4a. Facility Name (If not institution, give street and number) Bon Secours Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | 4c. County of Death N/A | | |
| 5. Social Security Number 212-16-6949 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) 2-28-1917 | | 9. Birthplace (State or Foreign Country) Md | | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Md | | 10b. County N/A | | 10c. City, Town or Location Balto | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 1947 Ridgehill Avenue | | | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? U S A | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | | 16b. Kind of Business/Industry Unk | | |
| 17. Father's Name (First, Middle, Last) John Hicks | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Martha Buchanan | | | |
| 19a. Informant's Name/Relationship (Type, Print) James Coates, Jr - NEPHEW | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4210 Norfolk Avenue Balto, Md 21216 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet | | | Date 5/12/2004 | | 20c. Location - City or Town, State Owings Mills, Md | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balt, Md 21215 | | | | | |
| 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hypotension SEPSIS Gastrointestinal BLEEDING Respiratory Failure | | | | | | | | | |
| 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | | | | | | | | |
| 23d. Date of delivery Month Day Year | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier Terence L. Lams MD | | | | 29c. License number D37203 | | | 29d. Date signed (Month, Day, Year) May 5th 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERENCE L. LAMS MD Bon Secours Hospital Baltimore md, | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | 32. Registrar's Signature | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 15117

| | | | | | | | | |
|---|---|---|---|---|---|---|--|--|
| Physician / Medical Examiner | 1. Decedent's Name (First, Middle, Last) GLADYS ESTELLE JOHNSON | | | | 2. Date of Death Month: MAY Day: 9 Year: 2004 | | 3. Time of Death 7:05AM | |
| | 4a. Facility Name (If not institution, give street and number) SINAI Hospital of Baltimore | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 212-46-5124 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV. 16 1944 | |
| | 9. Birthplace (State or Foreign Country) VIRGINIA | | 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 3321 ST AMBROSE AVENUE | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry N/A | | | |
| | 17. Father's Name (First, Middle, Last) WILLIAM SCOTT JR | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARIA JEFFERSON | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Danielle Johnson/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3321 St. Ambrose Avenue, Baltimore, MD, 21215 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VETERANS 05-17-04 OWINGS MILLS, MARYLAND | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Home Licensee | | | | 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. LOWER GASTROINTESTINAL BLEED Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 12 HOURS 2 HOURS | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28c. Describe how injury occurred | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number RES 0000 | | 29d. Date signed (Month, Day, Year) MAY 9, 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DELORENZO D.O. SINAI Hospital of Baltimore | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15118

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNIE M. JACOBS

2. Date of Death

Month Day Year
MAY 10 2004

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

2065 Montevideo Road

4b. City, Town, or Location of Death

Jessup

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

170-05-9446

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sep. 19, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Jessup

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2065 Montevideo Road

10f. Zip Code

20794

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4or 5+)
216a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Gardener

16b. Kind of Business/Industry

Own Business

17. Father's Name (First, Middle, Last)

Franklin Heinrich

18. Mother's Name (First, Middle, Maiden Surname)

Magdeline Horvatt

19a. Informant's Name/Relationship (Type, Print)

Francis Jacobs - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2065 Montevideo Road Jessup, Maryland 20794

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

5/13/04

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

M. Pgh

22. Name and Address of Facility

Gary L. Kaufman Funeral Home At MMP., Inc.
7250 Washington Blvd. Elkridge, Maryland 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY HYPERTENSION

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
YEARS

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death
☐ Pregnant at time of death
☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis Chvidian MD

29c. License number

D42892

29d. Date signed (Month, Day, Year)

MAY 11, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS CHVIDIAN 10724 LITTLE PATUXENT PARKWAY, COLUMBIA, MD 21044

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Keren B. Spivey

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15119

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

THURMAN CALVIN JONES

2. Date of Death

M MAY 04, 2004

3. Time of Death

6: 30 P^M

4a. Facility Name (If not institution, give street and number)

RAVENWOOD LUTHERAN VILLAGE

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

215-18-1594

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 9, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1183 Luther Drive

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1942-1943

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Metal Former & Finisher

16b. Kind of Business/Industry

Aircraft Manufacture

17. Father's Name (First, Middle, Last)

Vinton J. Jones

18. Mother's Name (First, Middle, Maiden Surname)

Edith Martz

19a. Informant's Name/Relationship (Type, Print)

Bernice Ann Wolfensberger Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10330 Mar Rock Drive, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rest Haven Cemetery

Date

05-08-04

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

R. Paul Brady

22. Name and Address of Facility

Andrew K. Coffman Funeral Home, Inc.

40 East Antietam Street, Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal Failure

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cerebrovascular accident

congestive heart failure

decubitus ulcer of heel

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Cynthia Kuttner-Sands, MD

29c. License number

D47451

29d. Date signed (Month, Day, Year)

May 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Kuttner-Sands, MD 14214 Paradise Church Road, Hagerstown, Maryland 21742

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JONES, Thurman Calvin

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15120

Certificate of Death

Reg. No.

1- For
State
Registrar

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERT Q. JACKSON | | | | 2. Date of Death Month MAY Day 8 Year 2004 | | 3. Time of Death 11:00a M | |
| | 4a. Facility Name (If not institution, give street and number) MARINER of CATONSVILLE | | | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 220-20-3157 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 25, 1930 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State M.D. | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 2710 Ellicott Drive | | 10f. Zip Code 21216 | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 1947 If Yes, Give Year or Dates: 1948 | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foundry Foreman | | | | 16b. Kind of Business/Industry Flynn & Emrich | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Alfred Francis Jackson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elvira Briscoe | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Vivian L. Jackson- Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2710 Ellicott Drive, Balto., M.D. 21216 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest | | 20c. Location - City or Town, State 5/14/2004 Owings Mills, M.D. | |
| | 21. Signature of Funeral Service Licensee Herbert E. Nutter | | | | 22. Name and Address of Facility Nutter Funeral Home Inc. 2501 Gwynnsfalls Pkwy, Balto., M.D. 21216 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Broncho-pneumonia Due to (or as a consequence of): b. Multiple Myeloma Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death One Week. Years. | | 23d. Date of delivery Month Day Year | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cervical Disc Disease and degeneration Quadruparesis. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) M 28b. Time of Injury 1 Yes <input type="checkbox"/> No <input type="checkbox"/> No 28c. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier N. B. Vellanki | | | |
| | 29c. License number D 30469. | | | | 29d. Date signed (Month, Day, Year) May 11, 2004. | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. B. Vellanki, MD; 9055 Chevrolet Drive, #100, Ellicott City, MD 21042. | | | | 31. Date filed (Month, Day, Year) MAY 12 2004 | | | |
| | 32. Registrar's Signature [Signature] | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15121

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILINDA HOPE JORDAN

2. Date of Death

Month Day Year
APR 18 2004

3. Time of Death

6:36 A M

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

N/A

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

4

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
April 14, 2004

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8901 Wisconsin Ave.

10f. Zip Code

20814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Eric M. Jordan

18. Mother's Name (First, Middle, Maiden Surname)

Karen O'Berst

19a. Informant's Name/Relationship (Type, Print)

Eric M. Jordan / Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8901 Wisconsin Ave., Bethesda, MD 20814

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maplewood Cemetery

Date

4/27/04

20c. Location - City or Town, State

Springville, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Smith-Weismantle Funeral Home
271 E. Main St., Springville, NY 14141

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PULMONARY HEMORRHAGE

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

EXTREME PREMATURITY

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

01051105A (IN)

29d. Date signed (Month, Day, Year)

04/21/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGNES SIEROCKA MAJ MC USA

NATIONAL NAVAL MEDICAL CENTER
BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15122

1- For State Registrar

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last)

ALICE JOYNER

2. Date of Death

May 9th 2004

3. Time of Death

10:00 P.M.

4a. Facility Name (If not institution, give street and number)

Northwest Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral Director

5. Social Security Number

241-82-3029

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 14, 1946

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

M.D.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5500 W. North Avenue

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Wife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jesse McPherson

18. Mother's Name (First, Middle, Maiden Surname)

Clora McPherson

19a. Informant's Name/Relationship (Type, Print)

Sabrina Joyner- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5500 W. North Avenue, Balto., M.D. 21207

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

5/11/2004

20c. Location - City or Town, State

Balto., M.D.

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility

Nutter Funeral Home Inc.
2501 Gwynnsfalls Pkwy, Balto., M.D. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial Infarction

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease

years

c. Atherosclerosis

years

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metabolic encephalopathy, Diabetic renal disease, Hypertension, Cerebrovascular disease

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

R. Ramaprasad MD

29c. License number

DS4288

29d. Date signed (Month, Day, Year)

May 9th 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramaprasad I. Ramaprasad

North West Hospital Center

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Benita B. Spence

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

2004 15123

1- For
State
Registrar

| | | | | | | | |
|---|---|---|--|---|--------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John JACKSON | | | 2. Date of Death Month Day Year MAY 8 2004 | | 3. Time of Death 1540pm | |
| | 4a. Facility Name (If not institution, give street and number) Mercy Hospital - Hospice | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213-28-3589 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 30, 1932 |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State M.D. | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 802 Argonne Drive | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1956 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2years College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly Line Worker | | 16b. Kind of Business/Industry Western Electric | |
| 17. Father's Name (First, Middle, Last) Theodore Jackson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Jordan | | | |
| 19a. Informant's Name/Relationship (Type, Print) Nellie Jackson - Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2109 Fernglen Way, Catonsville, M.D. 21228 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cem. | | Date 5/17/2004 | | 20c. Location - City or Town, State Pikesville, M.D. | |
| 21. Signature of Funeral Service Licensee Herbert E. Nutter | | | | 22. Name and Address of Facility Nutter Funeral Home Inc. 2501 Gwynnstalls Pkwy, Balto., M.D. 21216 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Jejunal cancer Approximate Interval Between Onset and Death | | | | | | | |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 3. Ectopic pregnancy <input type="checkbox"/> Other (Specify) | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) hospice | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Dr. [Signature] | | | | 29c. License number D40854 | | 29d. Date signed (Month, Day, Year) 5/10/2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Rieseberg 301 St Paul Place Baltimore 21202 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature [Signature] | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15124

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth K. Johnson

2. Date of Death

Month Day Year
May 10, 2004

3. Time of Death

5:15 A M

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

216-24-0778

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 20, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

203 Williamsburg Drive

10f. Zip Code

20901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Doctor's Office

17. Father's Name (First, Middle, Last)

Roy B. Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Lotta K. Sapp

19a. Informant's Name/Relationship (Type, Print)

David R. Campbell/ Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

203 Williamsburg Drive, Silver Spring, MD 20901

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Montgomery
Crematorium, Inc.

Date

May 12, 2004

20c. Location - City or Town, State

Bethesda,
Maryland

21. Signature of Funeral Service Licensee

M00689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue,
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shot, or heart failure. List only one cause on each line.Immediate Cause: Final
disease or condition
resulting in deathSequentially list conditions,
if any, leading to immediate
cause. Enter underlying
Cause (Disease or injury
that initiated events
resulting in death) Lasta. *Cardiopulmonary Arrest*
Due to (or as a consequence of):
b. *congestive Heart Failure*
Due to (or as a consequence of):
c. *Atherosclerotic Coronary Artery Disease*
Due to (or as a consequence of):
d.Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D57649

29d. Date signed (Month, Day, Year)

05/10/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bryan M. Steinberg, M.D. 106 Irving Street, NW, #2400N, Washington, DC 20010-2986

State
Registrar

31. Date filed (Month, Day, Year)

MAY 1 2 2004

32. Registrar's Signature

Bryan M. Steinberg

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15125

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RAY JOHNSON

2. Date of Death

May 6, 2004

Day

Year

3. Time of Death

5:30pm M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Lorien Nursing Home @ Frankford

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

225 16 8401

6. Sex

15 M 20 F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 14, 1927

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1931 N. PATTERSON PARK

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: 4-16-43
4-25-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

LABORER

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

BALTIMORE CITY
SANITATION DEPT

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

RAY JOHNSON JR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 9TH APT. 538 ST. LOUIS, MD 63101

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST OWINGS MILLS, MARYLAND

Date

MAY 13, 2004

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bernadine V. Scruggs

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTIMORE, MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ASVCD

a. Due to (or as a consequence of):

CHF

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (Specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

MD

29c. License number

D57727

29d. Date signed (Month, Day, Year)

5/11/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Navender Bhargava, 201-109 Bath River Neck Road, MD 21221

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15126

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIE O. JONES-BRYANT

2. Date of Death

Month Day Year
MAY 9, 2004

3. Time of Death

9:05 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

231-60-8178

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
6-7-1946

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1120 POPLAR GROVE ST.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

-10-

College (1-4or 5+)

-0-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

DIETARY

16b. Kind of Business/Industry

CORRECTION

17. Father's Name (First, Middle, Last)

SOLOMON LEWIS

18. Mother's Name (First, Middle, Maiden Surname)

MARY E. BOOTHE

19a. Informant's Name/Relationship (Type, Print)

ROSCOE BRYANT (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1120 POPLAR GROVE ST. BALTIMORE, MARYLAND 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

METROPOLITAN BAPT CHURCH

Date

5-15-2004

20c. Location - City or Town, State

CHURCHVIEW, VIRGINIA

21. Signature of Funeral Service Licensee

JONATHAN D. HIBNER

Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.

1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. SEPSIS

Due to (or as a consequence of):

END STAGE RENAL FAILURE

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joginder P Mehta M.D.

29c. License number

D 41410

29d. Date signed (Month, Day, Year)

May 9th, 2004.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15127

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|---|--|---|---|--|---|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Roger James | | | | 2. Date of Death Month Day Year April 26, 2004 | | | | 3. Time of Death 0850 A. M | | | |
| | 4a. Facility Name (If not institution, give street and number) 2816 E. Monument Street | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | | |
| Funeral Director | 5. Social Security Number 127-40-4697 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 55 Yrs. | | 8. Date of Birth (Month, Day, Year) August 30, 1949 | | 9. Birthplace (State or Foreign Country) NY | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 2816 E. Monument Street | | | | 10f. Zip Code 21205 | | 10g. Citizen of What Country? USA | | | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security Guard | | | | 16b. Kind of Business/Industry Abacus Corp. | | | |
| | 17. Father's Name (First, Middle, Last) Cleveland James | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rose Ayers | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Trina James/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 95-13 Northern Blvd, Elmhurst NY 11369 | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory | | | | Date May 10, 2004 | | 20c. Location - City or Town, State Baltimore, MD | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Hari P. Close Funeral Service, P.A. 709 Tessier Street, Baltimore MD 21201 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DIABETIC KETOACIDOSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 26. Place of Death (Check only one) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) April 27, 2004 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature | | | | | | | | | | |

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **AMEND ITEM #20b PER FH G831 5/18/04** **Certificate of Death**Reg. No. **2004 15128**

| | | | | | |
|---|--|--|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rodney Johnson | | 2. Date of Death Month Day Year MAY 6, 2004 | | 3. Time of Death 11:00p M |
| | 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 217-23-2656 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 17 Yrs. | 8. Date of Birth (Month, Day, Year) Sept. 20, 1986 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County N/A | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 3711 N. Rogers Ave. | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? USA |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student | | 16b. Kind of Business/Industry High School |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Rodney Johnson Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Mae Veney | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ms. Sandra Canty | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3637 Chesterfield Ave. Balto. Md. 21213 | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | 20c. Location - City or Town, State Balto. Md. |
| | 21. Signature of Funeral Service Licensee Joseph L. Russ | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound of right arm and chest Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death |
| | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 23d. Date of delivery Month Day Year | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) May 6, 2004 | | 28b. Time of Injury 10:20 PM |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject was shot | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) road | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4000 Blockold York Rd, Baltimore, MD | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29c. License number OCME |
| | 29b. Signature and title of certifier Tasha Zareentberg MD | | 29d. Date signed (Month, Day, Year) MAY 7, 2004 | | 29e. Date of death (Month, Day, Year) MAY 6, 2004 |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Zareentberg MD 111 Penn Street, Baltimore, Maryland 21201 | | | | 31. Date filed (Month, Day, Year) MAY 12 2004 |
| | 32. Registrar's Signature B. Sparks | | | | |

Baltimore, Maryland 21215-0036

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15129

1- For State Registrar

| | | | | | | | | | | | |
|--|--|---------------------------------|---|---|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harry A. Kraft | | | | 2. Date of Death Month May Day 3 Year 2004 | | | | 3. Time of Death 12:30 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Pickersgill Retirement Center | | | | 4b. City, Town, or Location of Death Towson | | | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 217-10-9685 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) Apr 12, 1914 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Towson | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 615 Chestnut Avenue | | | | 10f. Zip Code 21204 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) salesperson | | | 16b. Kind of Business/Industry unk | | | | |
| 17. Father's Name (First, Middle, Last) Harry Hollinger Kraft | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Bella Pearl Fletcher | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Pickersgill Retirement Center | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Chestnut Avenue Towson, MD 21204 | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. oropharyngeal dysphagia of unknown etiology Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death months | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. prostate cancer | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier W. A. Riley, MD | | | | 29c. License number D25205 | | 29d. Date signed (Month, Day, Year) May 3, 2004 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley, G. Brink 6701 N. Charles St. Balto. md 21204 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | 32. Registrar's Signature Sparks | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15130

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Catherine Keenan

2. Date of Death

May 10, 2004

3. Time of Death

2:30P M

4a. Facility Name (If not institution, give street and number)

Oak Crest Retirement

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

264-52-0501

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec. 11, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4 Fieldsway Court

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Gately

18. Mother's Name (First, Middle, Maiden Surname)

Adelaide Fronz

19a. Informant's Name/Relationship (Type, Print)

Mary Angela Liberto/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Fieldsway Court Baltimore, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Balt. Wash. Crem.

Date

05/12/2004

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Bradley-Ashton-Matthews Funeral Home, Inc.

2134 Willow Spring Road Balt., MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Coronary artery disease*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation
hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Dr. An Monies, M.D.

29c. License number

D58646

29d. Date signed (Month, Day, Year)

May 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parkville, MD 21234

8500 Walther Boulevard

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

*[Signature]*State
RegistrarCatherine Keenan 05/10/2004 2:30PM.
Baltimore, Maryland 21215-0036
perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
 1- Amend Item 23pt. 11&25 per me 6841 3-2-05 tas
 Certificate of Death
 Reg. No. 2004 15131

| | | | | | | | | |
|--|---|--|---|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LUCINDA L. KNAPP | | | | 2. Date of Death Month Day Year May 9 2004 | | 3. Time of Death 10:07 PM | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 212-76-8008 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 44 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 6/7/1959 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 5 Bexleigh Court, Apt. 3 | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insurance Clerk | | | 16b. Kind of Business/Industry Insurance Company | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Howard T. Epsey | | | | 18. Mother's Name (First, Middle, Maiden Surname) Arlene E. Brock | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Howard T. Epsey/Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2265 Phillips Mill Road, Forest Hill, MD 21050 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens | | Date 5/11/2004 | | 20c. Location - City or Town, State Bel Air, MD | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 | | | | | |
| Physician /Medical Examiner | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Subarachnoid Hemorrhage Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Excessive Alcohol use | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Sudhakar Papineni | | | | 29c. License number Res 000 | | 29d. Date signed (Month, Day, Year) 5-7-04 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sudhakar Papineni, 9000 Franklin Square Drive Baltimore MD 21237 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15132

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

WILLIAM A.

KELLY, SR.

2. Date of Death

Month Day Year
MAY 11, 2004

3. Time of Death

4:42 A.M.

4a. Facility Name (If not institution, give street and number)

1623 HARDWICK ROAD

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

218-28-8824

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7/6/1932

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1623 HARDWICK ROAD

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: KOREAN13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12TH GRADE

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

BREWERY

17. Father's Name (First, Middle, Last)

WILLIAM A. KELLY

18. Mother's Name (First, Middle, Maiden Surname)

HELEN BUCHMAN

19a. Informant's Name/Relationship (Type, Print)

EILEEN T. KELLY

WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1623 HARDWICK ROAD TOWSON, MD 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

5/14/2004

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

M. Leaf Colman

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. VENTRICULAR DYSRHYTHMIA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

MINS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

YRS.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard Biggs, MD

29c. License number

20500562

29d. Date signed (Month, Day, Year)

5-11-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard Biggs, MD 7505 Osler Drive Suite 103 Baltimore, MD 21239

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Luan to Spence

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15133

1- For
State
Registrar

| | | | | | | | | |
|---|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) David Lehman | | | | 2. Date of Death Month 5 Day 1 Year 04 | | 3. Time of Death 8:05 A M | |
| | 4a. Facility Name (If not institution, give street and number) Atlantic General Hospital | | | | 4b. City, Town, or Location of Death Berlin | | 4c. County of Death Worcester | |
| Funeral Director | 5. Social Security Number 218-40-9094 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) June 11, 1944 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State DE | | 10b. County unk | | 10c. City, Town or Location Selbyville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 62 E. Church Street | | 10f. Zip Code unk | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Funeral Director | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) police officer | | | | 16b. Kind of Business/Industry law enforcement | | 17. Father's Name (First, Middle, Last) Leo Joseph Lehman Sr | |
| To Be Completed by Funeral Director | 18. Mother's Name (First, Middle, Maiden Surname) unk | | | | 19a. Informant's Name/Relationship (Type, Print) Donna Bowling/daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9475 Trinity Church Road Charlotte Hall, MD 20622 | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Date | | 20c. Location - City or Town, State | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 2 weeks | | | |
| To Be Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | |
| | 23d. Date of delivery Month Day Year | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier D.O. | | | | 29c. License number H44283 | | | |
| | 29d. Date signed (Month, Day, Year) 5/1/04 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert D. ... 9733 Hillman Drive Berlin, MD | | | |
| State Registrar | 31. Date filed (Month, Day, Year) MAY 1 2 2004 | | | | 32. Registrar's Signature B. Sparks | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15134

1- For State Registrar

Physician / Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) Bo Dan Luciw
2. Date of Death Month Day Year May 10 2004
3. Time of Death 9:00 P M

4a. Facility Name (If not institution, give street and number) St. Johns Community Nursing Center
4b. City, Town, or Location of Death Baltimore
4c. County of Death

5. Social Security Number 160-26-5089
6. Sex 1 M 2 F
7. Age (In yrs. last birthday) 89 Yrs.
8. Date of Birth (Month, Day, Year) July 15, 1914
9. Birthplace (State or Foreign Country) Ukraine

Usual Residence of Decedent
10a. State Maryland
10b. County
10c. City, Town or Location Baltimore
10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 16 S. Patterson Park Ave.
10f. Zip Code 21231
10g. Citizen of What Country? United States

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Engineer
16b. Kind of Business/Industry Engineering

17. Father's Name (First, Middle, Last) Alexander Luciw
18. Mother's Name (First, Middle, Maiden Surname) Unknown

19a. Informant's Name/Relationship (Type, Print) George Luciw - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1422 Woodview Rd., Yardley, PA 19067

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Ukr. Catholic Cemetery
20c. Location - City or Town, State 5/14/2004 Elkins Park, PA

21. Signature of Funeral Service Licensee
22. Name and Address of Facility Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd., ElkrIDGE, MD 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) a. Sepsis
Due to (or as a consequence of):
b. Urinary Tract Infection
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last
IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dehydration
23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No
26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert C. Dart, MD, 901 E. Fort Ave., Baltimore, MD 21230

31. Date filed (Month, Day, Year) MAY 12 2004
32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15135

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | |
|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Howard Francis Lipinski, Jr. | | 2. Date of Death Month Day Year May 10, 2004 | | 3. Time of Death 10:15 a.m. |
| 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore |
| 5. Social Security Number 216-36-1850 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | 8. Date of Birth (Month, Day, Year) July 14, 1939 | 9. Birthplace (State or Foreign Country) Maryland |

| | | | | |
|-----------------------------|--------------------------|---|--|--|
| Usual Residence of Decedent | | 10c. City, Town or Location Middle River | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10a. State Maryland | 10b. County Baltimore | | | |

| | | |
|--|------------------------|--|
| 10e. Street and Number 9901 Van Tassel Lane | 10f. Zip Code 21220 | 10g. Citizen of What Country? United States |
|--|------------------------|--|

| | | | |
|--|---|--|--|
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc. Specify: White |
|--|---|--|--|

| | | | |
|---|--|---|---|
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Banker | 16b. Kind of Business/Industry Federal Reserve |
|---|--|---|---|

| | |
|---|--|
| 17. Father's Name (First, Middle, Last) Howard Francis Lipinski, Sr. | 18. Mother's Name (First, Middle, Maiden Surname) Emma Eva Grob |
|---|--|

| | |
|---|---|
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Marlene E. Higgins /Sister | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7312 Manchester Road Dundalk, Maryland 21222 |
|---|---|

| | | | |
|---|---|-------------------|--|
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | Date 5/13/2004 | 20c. Location - City or Town, State Baltimore, Maryland |
|---|---|-------------------|--|

| | |
|---|---|
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 |
|---|---|

| | | |
|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Liver Failure Due to (or as a consequence of): b. alcoholic liver cirrhosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | |

| | | |
|---|--|---|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | 23d. Date of delivery Month Day Year |
|---|--|---|

| | | |
|---|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal failure cerebral vascular disease peripheral vascular disease | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |

| | | |
|--|--|--------------------------|
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | 28a. Date of Injury (Month, Day Year) M | 28b. Time of Injury M |

| | | |
|---|---------------------------------|--|
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29c. License number Res 0000 | 29d. Date signed (Month, Day, Year) 5/10/04 |
|---|---------------------------------|--|

| | | |
|--|--|---|
| 29b. Signature and title of certifier <i>[Signature]</i> | 29e. Date of death (Month, Day, Year) MAY 12 2004 | 32. Registrar's Signature <i>[Signature]</i> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Mikityanskaya, md, 9000 Franklin Square Drive Baltimore MD 21237 | | |

State Registrar

Lipinski, Howard

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15136

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

McArthur Joseph Lewis

2. Date of Death

Month Day Year
May 4, 2004

3. Time of Death

2:02 A^M

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

229-62-6900

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 3, 1947

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7600 Maple Ave. Apt. #1503

10f. Zip Code

20912

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

15a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Cleaning

17. Father's Name (First, Middle, Last)

Raleigh Lewis, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Davis

19a. Informant's Name/Relationship (Type, Print)

Mrs. Patricia S. Lewis (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7600 Maple Ave. Apt. #1503 Takoma Park, MD 20912

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

May 8, 2004

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

A.L. Bennett Funeral Home, Inc.
515 Princess Anne St., Fredericksburg, VA 2240423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
3 Weeks

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

Adult Respiratory Distress Syndrome

23a. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an
autopsy
performed?
☐ Yes ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D225009

29d. Date signed (Month, Day, Year)

May 4, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pamela Mulshine, M.D. 10801 Lockwood Dr., Silver Spring, MD 20901

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15137

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SEUNG JUN LEE

2. Date of Death

Month Day Year
MAY 04 04

3. Time of Death

22:50 PM

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL SYS

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

214-63-3469

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT 1, 1963

9. Birthplace (State or Foreign Country)

KOREA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3214 B E. JOPPA ROAD

10f. Zip Code

21234

10g. Citizen of What Country?

KOREA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: ASIAN

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

OWNER

16b. Kind of Business/Industry

FOOD ESTABLISHMENT

17. Father's Name (First, Middle, Last)

WON KIL LEE

18. Mother's Name (First, Middle, Maiden Surname)

BYUNG YE OH

19a. Informant's Name/Relationship (Type, Print)

MONICA M. LEE / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3214 B E. JOPPA ROAD, PARKVILLE, MD 21234

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

EVANS FUNERAL CHAPEL - BEL AIR

Date

MAY 7, 2004

20c. Location - City or Town, State

FOREST HILL, MARYLAND

21. Signature of Funeral Service Licensee

Scott J. Johnson

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES,
8800 HARFORD RD, PARKVILLE, MD 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. GUN SHOT WOUND TO HEAD

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 Hour

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an
autopsy
performed?
☐ Yes ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
☐ Yes ☒ No25. Was case referred to medical
examiner?
☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☒ VER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☒ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)
MAY 04, 04

28b. Time of Injury

21:50 PM

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

SELF INFLECTED

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

3214 Joppa Road, Parkville, Md.

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard M. Peterson M.D.

29c. License number

P 15640

29d. Date signed (Month, Day, Year)

MAY 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard M. Peterson

22 SOUTH GREENE ST.

BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15138

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gertrude Loncala

2. Date of Death

Month Day Year
May 10, 2004

3. Time of Death

3:46 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-14-4768

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

February 26, 1925

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9016 Avenue A

10f. Zip Code

21219

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 8 years
College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank Zubrowski

18. Mother's Name (First, Middle, Maiden Surname)

Regina Fryza

19a. Informant's Name/Relationship (Type, Print)

Edward C. Loncala Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9016 Avenue A, Edgemere, Md. 21219

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cemetery

Date

May 13, 2004

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21222

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. BRAIN CANCER

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tariq Mahmood

29c. License number

D43725

29d. Date signed (Month, Day, Year)

5/10/04

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Benita S. Sparks

State
Registrar

MAY 10, 2004 3:46 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

GERTRUDE LONCALA

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15139

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) SARA ROSALIE LEVEN | | | 2. Date of Death Month MAY Day 9 , Year 2004 | | 3. Time of Death 3:30 A M |
| 4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT CENTER | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE |
| 5. Social Security Number 215-09-2550 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 96 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) SEP. 4, 1907 |
| 9. Birthplace (State or Foreign Country) MD | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County BALTIMORE | 10c. City, Town or Location PIKESVILLE | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 7920 SCOTTS LEVEL ROAD | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONTOMETER OPERATOR | | 16b. Kind of Business/Industry OFFICE |
| 17. Father's Name (First, Middle, Last) SOLOMON POSNER | | | 18. Mother's Name (First, Middle, Maiden Surname) SYLVIA KATZMAN | | |
| 19a. Informant's Name/Relationship (Type, Print) SELMA MOSGIN / DAUGHTER | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8804 ALLENSWOOD ROAD - RANDALLSTOWN, MD 21133 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MIKRO KODESH BETH ISRAEL | | Date 5/10/04 |
| 20c. Location - City or Town, State BALTIMORE, MD | | | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | |
| 22. Name and Address of Facility SOL LEVINSON & BROS., INC. | | | 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CEREBRAL THROMBOSIS | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | | | | |
| 23d. Date of delivery Month Day Year | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day Year) | | | | | |
| 28b. Time of Injury M | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Jasneem Lakhtani</i> | | | | | |
| 29c. License number D28595 | | | | | |
| 29d. Date signed (Month, Day, Year) 5/10/04 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JASNEEM LAKHTANI, 7220 PARK HEIGHTS AVE BALTO MD 21208 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | | |
| 32. Registrar's Signature <i>[Signature]</i> | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15140

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

PRESTON MCNICKELS, JR

2. Date of Death

Month Day Year
MAY 9 2004

3. Time of Death

235 A M

4a. Facility Name (If not institution, give street and number)

HARFORD MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

HAVERDE GRACE

4c. County of Death

HARFORD

5. Social Security Number

353-42-4509

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 2 1948

9. Birthplace (State or Foreign Country)

MISSISSIPPI

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HARFORD CO

10c. City, Town or Location

ABERDEEN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

461 RUBY DRIVE

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

MOVING/STORAGE

17. Father's Name (First, Middle, Last)

PRESTON McNICKLES SR

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE R. McNICKELS

19a. Informant's Name/Relationship (Type, Print)

Dr. Sheron Finister/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10536 Highway 183 West, Franklin, La., 70538

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HAYES CEMETERY

Date

05-16-04

20c. Location - City or Town, State

WAYNE CO, MISSISSIPPI

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A.
321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0014206

29d. Date signed (Month, Day, Year)

May 9, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERNARD J. YUKNA, MD, DME 7018 HOLABIRD AVE BALTO MD 21222

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15141

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Francis Molesky

2. Date of Death

May 6, 2004

3. Time of Death

9:10 P M

4a. Facility Name (If not institution, give street and number)

Edenwald

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

215-44-7992

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 19, 1908

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

800 Southerly Road

10f. Zip Code

21204

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Chief of Audit

16b. Kind of Business/Industry

Internal Revenue
Service

17. Father's Name (First, Middle, Last)

Alexander Modzeleski

18. Mother's Name (First, Middle, Maiden Surname)

Anna Kawalski

19a. Informant's Name/Relationship (Type, Print)

Thomas Molesky/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19540 Butternut, Southfield, MI 48076

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dulaney Valley Mem. Grns

Date

05/11/2004

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

D. C. C. C.

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Road Towson, MD 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter underlying
cause (disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

10 yrs

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)

29b. Signature and title of certifier

D. C. C. C.

D 29 769

29c. License number

29d. Date signed (Month, Day, Year)

5/10/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Monarchino D. Molesky

516 W. Rolling Rd Baltimore 21228

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

D. C. C. C.

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15142

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen C. MacMillan

2. Date of Death

Month Day Year
May 06, 2004

3. Time of Death

6:30 PM

4a. Facility Name (If not institution, give street and number)

Holly Hill Manor

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

174-38-3483

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 05 1906

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5313 Stevenson Lane

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Joseph Curry

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Roach

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Markum/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1695 Deep Run Rd. Whiteford, Md. 21160

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Grand View Mem. Park

Date

5-11-04

20c. Location - City or Town, State

Annaville, Pa.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute renal failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic cardiovascular disease
Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Inna Gendelsman M.D.

29c. License number

057454

29d. Date signed (Month, Day, Year)

May 07, 2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Inna Gendelsman, MD 1205 York Rd. Lutherville, Md. 21093

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

ASCD
5-6-04 6:30 pm
MacMillan, Helen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15143

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT FRANKLIN MYERS

2. Date of Death

May 6th 2004

3. Time of Death

5:00 am^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Reeder's Memorial Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

5. Social Security Number

215-36-6946

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 24, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Boonsboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

141 South Main Street

10f. Zip Code

21722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

State Highway Adm.

17. Father's Name (First, Middle, Last)

Jacob Rush Myers

18. Mother's Name (First, Middle, Maiden Surname)

Louisa Gertrude Misack

19a. Informant's Name/Relationship (Type, Print)

Alice Lavada Myers Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12843 St. Paul Road, Clear Spring, Maryland 21722

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematorium 05-07-04

Date

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

R. Joel Brady

22. Name and Address of Facility

Andrew K. Coffman Funeral Home, Inc.

140 East Antietam Street, Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause, or Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arterio Sclerotic Cerebrovascular Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Heart Failure Arterio Sclerotic

Arterio Sclerotic Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Vasant Datta

29c. License number

D18019

29d. Date signed (Month, Day, Year)

May 6, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vasant Datta, 340 Mills Street, Hagerstown, MD 21740 301-739-7100

State
Registrar

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

Name: Myers, Robert
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15144

1- For State Registrar

Physician / Medical Examiner

Funeral Director

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) William Taylor Monks, Sr. | | | | 2. Date of Death Month 05 Day 09 Year 2004 | | 3. Time of Death 1:50 PM | |
| 4a. Facility Name (If not institution, give street and number) 14006 Baldwin Mill Road | | | | 4b. City, Town, or Location of Death Baldwin | | 4c. County of Death Baltimore | |
| 5. Social Security Number 214-20-2726 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | | 8. Date of Birth (Month, Day, Year) 11/03/1908 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Glen Arm | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 12126 Hooper Lane | | | | 10f. Zip Code 21057 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanist | | 16b. Kind of Business/Industry Catholic Sisters Home | |
| 17. Father's Name (First, Middle, Last) William Taylor Monks | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Alice Lingan | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ruth S. Snyder (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Bluestone Court - Kingsville, MD 21087 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gdns. | | 20c. Location - City or Town, State 05/13/2004 Bel Air, Maryland | |
| 21. Signature of Funeral Service Licensee E. F. Lassahn | | | | 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, MD 21087 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic prostate cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| Approximate Interval Between Onset and Death 2 years | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure | | | | | | 23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Dr. Joseph A. Adams | | | | 29c. License number D32783 | | 29d. Date signed (Month, Day, Year) 5/10/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Joseph A. Adams 6701 North Charles St #4101 Towson, MD 21204 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | 32. Registrar's Signature [Signature] | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

6

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 151145

1- For State Registrar

| | | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HERBERT JAMES MILLINER | | | | 2. Date of Death Month May Day 3 Year 2004 | | 3. Time of Death 8:53 A M | |
| | 4a. Facility Name (If not institution, give street and number) 10 Standard Avenue | | | | 4b. City, Town, or Location of Death Crisfield | | 4c. County of Death Somerset | |
| Funeral Director | 5. Social Security Number 227-24-2107 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) March 19, 1928 | |
| | 9. Birthplace (State or Foreign Country) virginia | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State Maryland | | 10b. County Somerset | | 10c. City, Town or Location Crisfield | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 10 Standard Avenue | | | | 10f. Zip Code 21817 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No World War II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) 10 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | 16b. Kind of Business/Industry Grocery Store | |
| | 17. Father's Name (First, Middle, Last) Oscar B. Milliner | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lula Parks | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Dorothy M. Milliner (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Standard Avenue - Crisfield, Maryland 21817 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parksley Cemetery | | Date May 6, 2004 | | 20c. Location - City or Town, State Parksley, Virginia | |
| | 21. Signature of Funeral Service Licensee Mary Beth Bradshaw-Pruitt | | | | 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, Maryland 21817 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiorgan System Failure Due to (or as a consequence of): b. Pancreatic Adenocarcinoma with Lung/Liver/Spleen Metastasis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 weeks 1 month | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHF DM Type II COPD | | | | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 26. Place of Death (Check only one) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | |
| 28a. Date of Injury (Month, Day Year) May 3, 2004 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier PHYSICIAN 29c. License number D0058662 29d. Date signed (Month, Day, Year) May 3, 2004 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Encarnita Santos-Tescon, M.D. - 830 Chesapeake Drive - Cambridge, Maryland 21613 | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 32. Registrar's Signature [Signature] | | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15146

1- For State Registrar

Certificate of Death

Reg. No.

| | | | | | | | |
|---|---|--|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William Joseph McGuire III | | | 2. Date of Death Month May Day 7 Year 2004 | | 3. Time of Death 6:20 p^M | |
| | 4a. Facility Name (If not institution, give street and number) 1746 Swinburne Avenue | | | 4b. City, Town, or Location of Death Crofton | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 220-78-1465 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 44 Yrs. | 8. Date of Birth (Month, Day, Year) Dec. 24, 1959 | | 9. Birthplace (State or Foreign Country) Alabama | |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Anne Arundel | 10c. City, Town or Location Crofton | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 1746 Swinburne Avenue | | | 10f. Zip Code 21114 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Financial Planner | | 16b. Kind of Business/Industry Finance | | |
| | 17. Father's Name (First, Middle, Last) William Joseph McGuire, Jr. | | | 18. Mother's Name (First, Middle, Maiden Surname) Jeannette Carter | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Cindy A. McGuire (Wife) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1746 Swinburne Avenue, Crofton, MD 21114 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Mem. Gardens | | 20c. Location - City or Town, State Davidsonville, MD | | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Glioblastoma Multiforme Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Lung metastases Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | Approximate Interval Between Onset and Death eighteen months |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lung metastases | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier | | 29c. License number 00051301 | | 29d. Date signed (Month, Day, Year) May 10, 2004 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kean Knept MD 900 Bestgate Rd suite 300 Annapolis, MD 21401 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15147

1- For State Registrar

Physician / Medical Examiner
Funeral Director

| | | | | |
|---|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) Joseph P. Markowski, JR. | | 2. Date of Death Month 5 Day 10 Year 2004 | | 3. Time of Death 0702 M |
| 4a. Facility Name (If not institution, give street and number) 7500 Woodhaven Ct. | | 4b. City, Town, or Location of Death Glen Burnie | | 4c. County of Death |
| 5. Social Security Number 219-32-5943 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | 8. Date of Birth (Month, Day, Year) 3-30-37 | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | | | |
| 10a. State MD | 10b. County | 10c. City, Town or Location Glen Burnie | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 7500 Woodhaven Ct. | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Highway Administration State of MD | | 16b. Kind of Business/Industry | | |
| 17. Father's Name (First, Middle, Last) Joseph P. Markowski, SR. | | 18. Mother's Name (First, Middle, Maiden Surname) Anna D. Savalina | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Burns | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4801 Long Green Rd, Glen Arm, MD 21057 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) EVANS FUNERAL CHAPEL - BELAIR | | 20c. Location - City or Town, State 5-15-04 Forest Hill, MD |
| 21. Signature of Funeral Service Licensee Kimberly A. Gentry | | 22. Name and Address of Facility BALTIMORE MD 21234 EVANS FUNERAL CHAPEL, 8800 HARFORD RD | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Huntington's Disease | | | | |
| Approximate Interval Between Onset and Death | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter in descending order of sequence (Disease or injury that initiated events resulting in death) Last | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | | | |
| 23d. Date of delivery Month Day Year | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) M 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier William P. Jones, MD 29c. License number DO6054 29d. Date signed (Month, Day, Year) 5/12/04 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 645 America 21035 | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature [Signature] | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #31 PER DVR G831 5/12/00 Certificate of Death

Reg. No.

2004 15148

| | | | | | |
|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Mary McOsfley</i> | | 2. Date of Death Month <i>May</i> Day <i>09</i> Year <i>2004</i> | | 3. Time of Death <i>2:05 AM</i> |
| | 4a. Facility Name (If not institution, give street and number) <i>Howard County General Hospital</i> | | 4b. City, Town, or Location of Death <i>Columbia</i> | | 4c. County of Death <i>Howard County</i> |
| Funeral Director | 5. Social Security Number <i>215-10-3284</i> | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>85</i> Yrs. | 8. Date of Birth (Month, Day, Year) <i>08/05/1918</i> | |
| | 9. Birthplace (State or Foreign Country) <i>MD</i> | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State <i>MD</i> | 10b. County <i>CARROLL</i> | 10c. City, Town or Location <i>WESTMINSTER</i> | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number <i>403 LONDON COURT</i> | | 10f. Zip Code <i>21157</i> | | 10g. Citizen of What Country? <i>U.S.A.</i> |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i> | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>HOMEMAKER</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOMEMAKER</i> | | 16b. Kind of Business/Industry <i>OWN HOME</i> |
| | 17. Father's Name (First, Middle, Last) <i>MORRIS</i> | | 18. Mother's Name (First, Middle, Maiden Surname) <i>KOPALD MATILDA FINK</i> | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>MARA ADKINS / DAUGHTER</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>403 LONDON COURT WESTMINSTER, MD 21157</i> | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>HEBREW YOUNG MEN</i> | | 20c. Location - City or Town, State <i>WOODLAWN, MD</i> |
| | 21. Signature of Funeral Service Licensee <i>Jay Alan J...</i> | | 22. Name and Address of Facility <i>SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208</i> | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Septic shock and fecal peritonitis</i> | | | | |
| | Approximate Interval Between Onset and Death <i>15 d</i> | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Perforated Transverse colon</i> | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | Due to (or as a consequence of): | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | |
| | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | |
| | 23d. Date of delivery Month Day Year | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Necrotizing fasciitis</i> <i>Atrophic Fimbria</i> <i>Chronic renal failure</i> | | | | |
| | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | |
| | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier <i>Udayan B Shal</i> | | 29c. License number <i>D25522</i> | | 29d. Date signed (Month, Day, Year) <i>5/10/04</i> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Udayan B Shal 30713350 William Ave Baltm - MD 21221</i> | | | | | |
| 31. Date filed (Month, Day, Year) <i>5/10/04 MAY 12 2004</i> | | 32. Registrar's Signature <i>Benita B. Spauld</i> | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15149

1- For State Registrar

Physician / Medical Examiner

Funeral Director

| | | | | | |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Joseph John Nowakowski | | 2. Date of Death Month Day Year May 9, 2004 | | 3. Time of Death 8:15 A ^M | |
| 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Ctr. | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| 5. Social Security Number 218-26-0241 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | 8. Date of Birth (Month, Day, Year) Sept. 13, 1928 | 9. Birthplace (State or Foreign Country) Maryland | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Dundalk | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 3450 McShane Way | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Field Ironworker Foreman | | 16b. Kind of Business/Industry Steel Industry | | | |
| 17. Father's Name (First, Middle, Last) Joseph Stanley Nowakowski | | | 18. Mother's Name (First, Middle, Maiden Surname) Caroline Klein | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Christine F. Nowakowski Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3450 McShaneway Dundalk, Maryland 21222 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cemetery 5/12/2004 | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE MYELOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 3 <input type="checkbox"/> Ectopic pregnancy 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number 029071 | | 29d. Date signed (Month, Day, Year) 5/10/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B21 N. EVAN ST BALTIMORE MD 21201 R. ANANDA KRISHNAN | | | | | |
| 31. Date (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15150

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

ALAN OWENS

2. Date of Death
Month May Day 11, Year 2004

3. Time of Death
7:00 P M

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

213-14-2373

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 5, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Woodbine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7200 Woodbine Road

10f. Zip Code

21797

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinest

16b. Kind of Business/Industry

Federal Gov.

17. Father's Name (First, Middle, Last)

Robert Owens

18. Mother's Name (First, Middle, Maiden Surname)

Annie Patterson

19a. Informant's Name/Relationship (Type, Print)

Jennifer A. Wright daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

247 W. Old Liberty Road Sykesville, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Mem. Park May 15, 2004 Sykesville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Burrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] JGINOCK P MENTA M.D.

29c. License number

00041410

29d. Date signed (Month, Day, Year)

May 11th, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15151

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Bashir Ahmad Otmany | | | | 2. Date of Death Month Day Year May 9, 2004 | | 3. Time of Death 10:18 AM | |
| 4a. Facility Name (If not institution, give street and number) 6110 Wilson Lane | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| 5. Social Security Number 482-42-1189 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 19, 1929 | |
| 9. Birthplace (State or Foreign Country) Afghanistan | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Bethesda | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 6110 Wilson Lane | | | | 10f. Zip Code 20817 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Engineer | | 16b. Kind of Business/Industry Consulting | |
| 17. Father's Name (First, Middle, Last) Not Available | | | | 18. Mother's Name (First, Middle, Maiden Surname) Not Available | | | |
| 19a. Informant's Name/Relationship (Type, Print) Yen P. Phung | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6110 Wilson Lane, Bethesda, Maryland 20817 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) National Memorial Park | | Date May 15, 2004 | | 20c. Location - City or Town, State Falls Church, Virginia | |
| 21. Signature of Funeral Service Licensee  | | M00198 | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive Heart Failure Hypertension | | | | | | | |
| Approximate Interval Between Onset and Death | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D0030791 | | 29d. Date signed (Month, Day, Year) May 10, 2004 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jean-Pierre Faure, M.D. 8218 Wisconsin Avenue #P-9, Bethesda, Maryland 20814 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature  | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

20

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15152

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Ralston Dale Phillips

2. Date of Death

May 5, 2004

3. Time of Death

6:40P M

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

096-22-7863

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 20, 1921

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3993 Chesapeake Drive

10f. Zip Code

21037

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1939-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 year

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Insurance Investigator

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Harry R. Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Winifred Dale

19a. Informant's Name/Relationship (Type, Print)

Melissa S. Phillips/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3993 Chesapeake Dr., Edgewater, MD 21037

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lakemont Cemetery

Date

5-8-04

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Multiple Rib Fractures - Skull Fracture
Due to (or as a consequence of):c. Refrigerated Wound 15 hrs
Due to (or as a consequence of):d. Asphyxiation
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 Days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Large Cell Cancer of Lung
COPD

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

April 29, 2004

28b. Time of Injury

(Month, Day, Year)

8:30 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28d. Describe how injury occurred

FELL WHILE WALKING TO BED

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3993 Chesapeake Dr. Edgewater, MD 21037

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D23557

29d. Date signed (Month, Day, Year)

May 6, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony M. Caputo, M.D. 139 Old Solomons Island Rd. Annapolis, MD 21401

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15153

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Doris A. Parker

2. Date of Death

Month

Day

Year

May

7

2004

3. Time of Death

8:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

6 Arthur Drive

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince Georges

5. Social Security Number

328 28 3535

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

4-21-14

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6 Arthur Drive

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Worthen Gillespie

18. Mother's Name (First, Middle, Maiden Surname)

Julia Lancaster

19a. Informant's Name/Relationship (Type, Print)

Lorraine Combs/Pers. Rep.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6904 Livingston Road Oxon Hill, MD. 20745

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel Cemetery

Date

5/11/04

20c. Location - City or Town, State

Croton, New York

21. Signature of Funeral Service Licensee

Geo. F. Kalas

22. Name and Address of Facility

Geo. F. Kalas Funeral Home

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Abdominal Aortic Aneurysm

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

101 Stonegate Dr Silver Spring MD 20905

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Hugh Holder MD

29c. License number

D 39501

29d. Date signed (Month, Day, Year)

5-7-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hugh Holder MD

101 Stonegate Dr Silver Spring MD 20905

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Doris A. Parker

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15154

1- For State Registrar

| | | | | | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|---|-----------------------------|--|------------------------------------|----|----|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Delores Roche | | | | 2. Date of Death Month Day Year April 24, 2004 | | 3. Time of Death 9:00 AM | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 2901 Edison Hgwy | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | | | | | | | |
| Funeral Director | 5. Social Security Number 214-01-0969 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) Apr 15, 1919 | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 2901 Edison Hgwy | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? USA | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) telephone operator | | 16b. Kind of Business/Industry communications | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Frederick Hofstetter | | | | 18. Mother's Name (First, Middle, Maiden Surname) Teresa Stallman | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Patricia Cummins/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 Edison Hgwy Baltimore, MD 21213 | | | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Vascular dementia</td> <td rowspan="4">Approximate Interval Between Onset and Death 3 years</td> </tr> <tr> <td>b. Cerebrovascular accident</td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Vascular dementia | Approximate Interval Between Onset and Death 3 years | b. Cerebrovascular accident | c. | d. |
| | Immediate Cause (Final disease or condition resulting in death) | a. Vascular dementia | Approximate Interval Between Onset and Death 3 years | | | | | | | | | | | |
| b. Cerebrovascular accident | | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Christine Bell-Laffey MD | | | | 29c. License number D33211 | | 29d. Date signed (Month, Day, Year) 4/29/04 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTINE BELL-LAFFEY MD 1407 York Rd Suite 309 Lutherville MD 21093 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature B. Sparks | | | | | | | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15155

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Janet Anna Renninger

2. Date of Death

May 4, 2004

3. Time of Death

5:30 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

7402 Edsworth Road

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

5. Social Security Number

216-36-6231

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 27, 1937

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7402 Edsworth Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Plank Farrier

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Janie

19a. Informant's Name/Relationship (Type, Print)

Linda Might / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7402 Edsworth Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hilltop Service Corp. 5/6/2004

Date

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

J. Crossan O'Donovan

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. Crossan O'Donovan, M.D.

29c. License number

D0007632

29d. Date signed (Month, Day, Year)

May 5, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Crossan O'Donovan, M.D. 2112 DUNDALK AVE., BALTO MD 21222

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Brenda B Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15156

1- For State Registrar

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

To Be Completed by Physician/Medical Examiner

State Registrar

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) BEATRICE M. RIDEOUT | | 2. Date of Death Month Day Year May 9, 2004 | | 3. Time of Death 8:15 a M | |
| 4a. Facility Name (If not institution, give street and number) 348 Melvin Avenue Apt.A | | 4b. City, Town, or Location of Death Catonsville | | 4c. County of Death Baltimore | |
| 5. Social Security Number 214-26-4891 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | |
| 8. Date of Birth (Month, Day, Year) Apr. 10, 1929 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State M.D. | | 10b. County Baltimore | | 10c. City, Town or Location Catonsville | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 348 Melvin Avenue Apt.A | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook | | 16b. Kind of Business/Industry Jennings Cafe | |
| 17. Father's Name (First, Middle, Last) William Gaither | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Hammond | | | |
| 19a. Informant's Name/Relationship (Type, Print) Frances Brown- Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 348 Melvin Avenue Apt.A, Catonsville, M.D. 21228 | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Location - City or Town, State Balto., M.D. | |
| 21. Signature of Funeral Service Licensee Herbert E. Nutter | | 22. Name and Address of Facility Nutter Funeral Home Inc. 2501 Gwynnsfalls Pkwy, Baltimore, M.D. 21216 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Heart Failure a. Due to (or as a consequence of): Septic Molds II b. Due to (or as a consequence of): Renal insufficiency c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Dr. Miguel Heredia | | 29c. License number D04971 | | 29d. Date signed (Month, Day, Year) 5/10/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Miguel Heredia, M.D. 413 Commonwealth Ave., Balto., M.D. 21228 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature B. Spencer | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15157

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NOVELLA

ROBINSON

2. Date of Death

Month Day Year

MAY 8, 2004

3. Time of Death

7:00a M

4a. Facility Name (If not institution, give street and number)

1811 Trenleigh Road

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

251-42-7159

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 24, 1916

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

M.D.

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1811 Trenleigh Road

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Benjamin Moses

18. Mother's Name (First, Middle, Maiden Surname)

Esther Damon

19a. Informant's Name/Relationship (Type, Print)

Delores Hamm - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1811 Trenleigh Rd., Parkville, M.D. 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

5/11/2004

20c. Location - City or Town, State

Balto., M.D.

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility Nutter Funeral Home Inc.

2501 Gwynnsfalls Pkwy, Balto., M.D. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined7 ☐ Pending investigation8 ☐ Could not be determined9 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D. Muller M.D.

29c. License number

D58120

29d. Date signed (Month, Day, Year)

May 10th 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROSEMARIE MARAS 5601 LOCH RAVEN BLVD, BALT MD 21234.

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

D. Muller

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15158

1- For
State
Registrar

| | | | | | |
|--|--|--|---|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Nellie</u> | | 2. Date of Death Month <u>May</u> Day <u>10</u> Year <u>2004</u> | | 3. Time of Death <u>10:00 PM</u> |
| | 4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Bayview Medical Center</u> | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>N/A</u> |
| Funeral Director | 5. Social Security Number <u>217-34-9621</u> | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>67</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) <u>February 13, 1937</u> | | 9. Birthplace (State or Foreign Country) <u>VA.</u> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State <u>Md.</u> | | 10b. County <u>Baltimore</u> |
| | 10c. City, Town or Location <u>Dundalk</u> | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number <u>7510 School Avenue</u> | | 10f. Zip Code <u>21222</u> | | 10g. Citizen of What Country? <u>USA</u> |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 years</u> College (1-4or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Security Guard</u> | | 16b. Kind of Business/Industry <u>Pinkerton Security</u> | | |
| | 17. Father's Name (First, Middle, Last) <u>Garwood E. Wagner</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Nellie Thompson</u> | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>Robert C. Rinker son</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8 Hydroplane Drive, Arco Acres, Md. 21220</u> | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Holly Hill Cemetery</u> | | 20c. Location - City or Town, State <u>May 14, 2004 Middle River, MD.</u> |
| | 21. Signature of Funeral Service Licensee <u>Anthony C. Connelly</u> | | 22. Name and Address of Facility <u>Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222</u> | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): b. <u>Chronic Obstructive Pulmonary disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death <u>one week</u> <u>ten years</u> |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>End stage renal disease</u> | | | | 23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier <u>Lynette Brown, M.D., Ph.D.</u> | | 29c. License number <u>RES-000</u> | | 29d. Date signed (Month, Day, Year) <u>May 11, 2004</u> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Lynette Brown, Johns Hopkins Hospital, 600 North Wolfe, Baltimore, MD 21287</u> | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) <u>MAY 12 2004</u> | | 32. Registrar's Signature <u>[Signature]</u> | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15159

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Horace J. Samples | | | | 2. Date of Death Month Day Year May 3, 2004 | | 3. Time of Death 2:40 PM | |
| 4a. Facility Name (If not institution, give street and number) 100 Revolution Street #611 | | | | 4b. City, Town, or Location of Death Havre de Grace | | 4c. County of Death Harford | |
| 5. Social Security Number 215-26-6130 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 95 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Mar 13, 1909 | |
| 9. Birthplace (State or Foreign Country) Pennsylvania | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Harford | | 10c. City, Town or Location Havre de Grace | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 100 Revolution Street #611 | | | | 10f. Zip Code 21078 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) dairy farmer | | 16b. Kind of Business/Industry agriculture | |
| 17. Father's Name (First, Middle, Last) Thomas David Samples | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lydia Getz | | | |
| 19a. Informant's Name/Relationship (Type, Print) Nancy White/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Revolution Street #111 Havre de Grace, MD 21078 | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Staphylococcal Sepsis Due to (or as a consequence of): b. pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 5 days 5 days | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. myelodysplasia prostate cancer | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Prashant Shukla | | | | 29c. License number 000048050 | | 29d. Date signed (Month, Day, Year) 5/5/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prashant Shukla, MD 155 Parke Street #400 Aberdeen MD 21001 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | 32. Registrar's Signature [Signature] | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15160

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN R SCOTT

2. Date of Death

Month

Day

Year

May

6

2004

3. Time of Death

9:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-32-4493

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 27, 1935

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2530 Lodge Forest Drive

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Millwright

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

John E. Scott

18. Mother's Name (First, Middle, Maiden Surname)

Veronica Potock

19a. Informant's Name/Relationship (Type, Print)

Mrs. F. Irene Scott / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2530 Lodge Forest Drive Edgemere, Maryland 21219

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith Cem.

Date

5/10/2004

20c. Location - City or Town, State

Rosedale, Maryland

21. Signature of Funeral Service Licensee

D. C. Cull

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate

Interval Between

Onset and Death

2 weeks

IF FEMALE

23b. Was decedent pregnant

in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE, DIABETES

END-STAGE RENAL DISEASE, HYPERTENSION,

NON-IRRITABLE MYOSITIS

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an

autopsy

performed?

☐ Yes ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

☐ Yes ☐ No

25. Was case referred to medical

examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

investigation

☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wendy Benner MD

29c. License number

P17964

29d. Date signed (Month, Day, Year)

May 6 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WENDY BENNER, MD 4940 EASTERN AVE. BALTIMORE MD 21224

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

B. Sparks

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

Certificate of Death

Reg. No. 2004 15161

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Phillip Stewart Jr

2. Date of Death

May 6 2004

3. Time of Death

7:43 M

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

405-46-2578

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 4, 1937

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

501 Wise Avenue

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1958-59

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

William Stewart

18. Mother's Name (First, Middle, Maiden Surname)

Hattie M. Osborne

19a. Informant's Name/Relationship (Type, Print)

Mrs. Laura A. Stewart / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 Wise Ave. Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 5/10/2004

Date

20c. Location - City or Town, State

Rosedale, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cerebral herniation

Due to (or as a consequence of):

b. Intracerebral Hemorrhage

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Minutes

7 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death

5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease, hypertension
diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident

3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] J. A. Rumbach, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MAY 7, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JEFFREY A. RUMBACH

440 Eastern Avenue, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

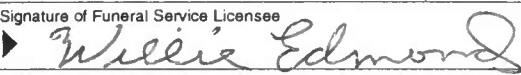
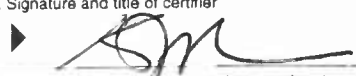

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **AMEND ITEM #14** per fh 831 5/12/04 **Certificate of Death**

Reg. No. **2004 15162**

| | | | | | | | | |
|--|--|-------------------------------|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sayed Salama Salama | | | | 2. Date of Death Month May Day 6 Year 2004 | | 3. Time of Death 7:44 PM | |
| | 4a. Facility Name (If not institution, give street and number) Upper Chesapeake Hospital | | | | 4b. City, Town, or Location of Death Edgewood | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 142-48-6086 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 61 Yrs. | | 8. Date of Birth (Month, Day, Year) 4-23-1943 | |
| | | | | | 9. Birthplace (State or Foreign Country) Egypt | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Md | | 10b. County Harford | | 10c. City, Town or Location Edgewood | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 301 Caspian Ct | | | | 10f. Zip Code 21040 | | 10g. Citizen of What Country? U S A | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: EGYPTIAN | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) Master's | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector | | 16b. Kind of Business/Industry Md Occupational Safety Health | | |
| 17. Father's Name (First, Middle, Last) Salama Abdul Hahab | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sania Kadous | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Amy Omayma Salama | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Caspian Ct Edgewood, Md 21040 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | Date 5-7-2004 | | 20c. Location - City or Town, State Randallstown, Md | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | a. Acute Myocardial Infarction | | | | Approximate Interval Between Onset and Death | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | b. Coronary Artery Disease | | | | 10 years | |
| | | | c. | | | | | |
| | | | d. | | | | | |
| | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier  MD | | | | 29c. License number MD072167L | | 29d. Date signed (Month, Day, Year) May 6, 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Madtes 500 Upper Chesapeake Dr Belair, Md 21014 | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | 32. Registrar's Signature  | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15163

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) David Charles Snyder | | | | 2. Date of Death Month May Day 8 Year 2004 | | 3. Time of Death 8:24 am | |
| 4a. Facility Name (If not institution, give street and number) Stella Maris | | | | 4b. City, Town, or Location of Death Timonium | | 4c. County of Death Baltimore | |
| 5. Social Security Number 386-26-9837 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) April 17, 1920 | |
| 9. Birthplace (State or Foreign Country) Michigan | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Ellicott City | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 2660 Legends Way | | | | 10f. Zip Code 21042 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> +5 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | 16b. Kind of Business/Industry Education | |
| 17. Father's Name (First, Middle, Last) John David Snyder | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Healy | | | |
| 19a. Informant's Name/Relationship (Type, Print) Anne Marie Snyder / Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2660 Legends Way Ellicott City, Maryland 21042 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. John's Cemetery | | 20c. Location - City or Town, State Ellicott City, Md. | |
| 21. Signature of Funeral Service Licensee <i>Carl A. Papp</i> | | | | 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cerebrovascular disease | | | | | | | |
| 23b. Part II. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial infarction | | | | | | | |
| 23c. Part III. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerosis | | | | | | | |
| 23d. Date of delivery Month May Day 8 Year 2004 | | | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) May 8, 2004 | | | | | | | |
| 28b. Time of Injury M | | | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <i>David Charles Snyder</i> | | | | | | | |
| 29c. License number 115504 | | | | | | | |
| 29d. Date signed (Month, Day, Year) 5-10-04 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD BALTIMORE MD 21093 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | | | | |
| 32. Registrar's Signature <i>David B. Sparks</i> | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State
Registrar

MAY 8, 2004 8:24 A.M.

SNYDER, DAVID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No. 2004 15164

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louis G. Sauer

2. Date of Death
Month Day Year
May 7, 20043. Time of Death
6:10 A^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

215-03-6310

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 12, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10535 York Road

10f. Zip Code

21030

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Builder

16b. Kind of Business/Industry

Home Construction

17. Father's Name (First, Middle, Last)

Louis H. Sauer

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Goetz

19a. Informant's Name/Relationship (Type, Print)

Mary Lou Adelman Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

914 Breezewick Road Towson, Maryland 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dufaney Valley Memorial Gardens

Date

5-7-2004

20c. Location - City or Town, State

Timonium Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Severe bullous emphysema

Approximate Interval Between Onset and Death
year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

renal failure

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice27. Manner of Death
1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury
M28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D25205

29d. Date signed (Month, Day, Year)

MAY 7, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley G3mc 6701 N. Charles St. Balt Md 21204

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LOUIS SAUER - MAY 7, 2004 @ 6:10AM

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15165

1- For
State
Registrar

| | | | | | | | | |
|---|---|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mildred Anna Skvarna | | | | 2. Date of Death Month Day Year May 10 2004 | | 3. Time of Death 9:25 A^M | |
| | 4a. Facility Name (If not institution, give street and number) Riverview Nursing Center | | | | 4b. City, Town, or Location of Death Essex | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 218-28-2790 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) July 14 1913 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Md. | | 10b. County Harford | | 10c. City, Town or Location Whiteford | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1894 Deep Run Road | | 10f. Zip Code 21160 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Store Manager | | 16b. Kind of Business/Industry Turkes Store | | | |
| | 17. Father's Name (First, Middle, Last) John Komendar | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Polacheck | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Frank Novack, III/ Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1894 Deep Run Rd. Whiteford, Md. 21160 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. | | Date 5-13-04 | | 20c. Location - City or Town, State Timonium, Md. | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Renal Failure Due to (or as a consequence of): | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D30641 | | 29d. Date signed (Month, Day, Year) May 11 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Sabapathi 201-109 Back River Neck Road Baltimore Maryland 21221 | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15166

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS SCHUER HOLZ

2. Date of Death

Month Day Year
May 10th 2004

3. Time of Death

1:00p M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

216-52-7929

6. Sex

☐ M ☒ F

7. Age (in yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 03, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

836 Kellogg Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harry L. Rayfield

18. Mother's Name (First, Middle, Maiden Surname)

Annie Marie Schley

19a. Informant's Name/Relationship (Type, Print)

Mrs. Kathryn Balint/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 Silver Stirrup Court Lutherville, Md. 21093

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Mem. Park

Date

5-14-04

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Renal Failure

Due to (or as a consequence of):

b. Type II Diabetes Mellitus

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
Weeks

Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy performed?
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ernestine Wright, MD

29c. License number

DS2 740

29d. Date signed (Month, Day, Year)

May 10th 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD 21093

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

MAY 10, 2004 1:00 P.M.

SCHUERHOLZ, DORIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15167

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)

Peter

Sakell

2. Date of Death

May 5 2004

3. Time of Death

1225 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

212-40-5706

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59

If Under 1 Year Months Days

If Under 24 Hrs. Hours Min.

8. Date of Birth (Month, Day, Year)

Feb. 11, 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1770 Langport Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Exterminator

16b. Kind of Business/Industry

Pest Control

17. Father's Name (First, Middle, Last)

Peter Sakell

18. Mother's Name (First, Middle, Maiden Surname)

Eugenia Stravrolamakos

19a. Informant's Name/Relationship (Type, Print)

Reene Sakell / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7401 Kenlea Ave. Nottingham, Maryland 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greek Orthodox Cem.

Date

5/8/2004

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

Stephanie Massey

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis Pseudomonas

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Skull based Osteomyelitis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

7 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic heart disease
Diabetes mellitus
Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

5/5/4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Subhash K. Patel, MD 4940 Eastern Avenue, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15168

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) CARL RICHARD STICHER 2. Date of Death Month MAY Day 10 Year 2004 3. Time of Death 6:30 P M

Funeral Director

4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE 4b. City, Town, or Location of Death BALTIMORE 4c. County of Death n/a

5. Social Security Number 182-16-6619 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 83 Yrs. 8. Date of Birth (Month, Day, Year) July 5 1920 9. Birthplace (State or Foreign Country) PA

Usual Residence of Decedent 10a. State Maryland 10b. County Carroll 10c. City, Town or Location Sykesville 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 911 Lee Ave. 10f. Zip Code 21784 10g. Citizen of What Country? United States

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sheet Metal Worker 16b. Kind of Business/Industry Government

17. Father's Name (First, Middle, Last) William F. Sticher 18. Mother's Name (First, Middle, Maiden Surname) Doris V. Seidal

19a. Informant's Name/Relationship (Type, Print) Debra Barnes daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Lee Ave. Sykesville, MD 21784

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date May 11, 2004 20c. Location - City or Town, State Sykesville Maryland

21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Road Sykesville, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INTRA-ABDOMINAL SEPSIS 23b. Approximate Interval Between Onset and Death 6 HOURS

23c. Due to (or as a consequence of): 23d. Due to (or as a consequence of): 23e. Due to (or as a consequence of): 23f. Due to (or as a consequence of):

23g. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE 23a. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Peter W. Cho M.D. Surgeon 29c. License number D41129 29d. Date signed (Month, Day, Year) MAY 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER W. CHO, M.D. SINAI HOSPITAL OF BALTIMORE, BALTIMORE, MARYLAND

State Registrar

31. Date filed (Month, Day, Year) MAY 12 2004 32. Registrar's Signature

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

STICHER, CARL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15169

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY JOSEPHINE KENNEDY SHAFFER

2. Date of Death

MAY 08 2004

3. Time of Death

10:15 P M

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

216-16-5594

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 30, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8810 Walther Blvd., #3307

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Public Relations Manager

16b. Kind of Business/Industry

C&P Company

17. Father's Name (First, Middle, Last)

Joseph Stephen Kennedy

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Ann Clark

19a. Informant's Name/Relationship (Type, Print)

James F. Shaffer (Step son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Ranger Court, Henderson, NV 89074

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery 5/11/2004 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE INTERSTITIAL PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 DAYS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

PATHOLOGIST

29c. License number

D14873

29d. Date signed (Month, Day, Year)

5/9/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES W. EAGAN, JR. M.D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

James W. Eagan

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **AMEND ITEM #1 PER PHY C831 5/12/04 JH** **Certificate of Death**

Reg. No. **2004 15170**

**Physician
/Medical
Examiner**

**Funeral
Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Sally M. Skurla | | 2. Date of Death Month May Day 04 Year 2004 | | 3. Time of Death 0840 M | |
| 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death | |
| 5. Social Security Number 218-67-7531 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. 7 Months 6 Days 6 Hours 6 Min. | |
| 8. Date of Birth (Month, Day, Year) Sept. 28, 2003 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Potomac | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 11109 Lamplighter Lane | | 10f. Zip Code 20854 | |
| 10g. Citizen of What Country? United States | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4or 5+) None | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None | | 16b. Kind of Business/Industry None | | | |
| 17. Father's Name (First, Middle, Last) Robert M. Skurla, Jr. | | 18. Mother's Name (First, Middle, Maiden Surname) Martha Cornell | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert M. Skurla, Jr./Father | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11109 Lamplighter Lane, Potomac, MD. 20854 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. Location - City or Town, State Silver Spring, Maryland | |
| 21. Signature of Funeral Service Licensee Robert A. Pumphrey M01353 | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. / 300 West Montgomery Avenue Rockville, Maryland 20850-2805 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Respiratory Distress Syndrome Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | |
| 23d. Date of delivery Month May Day 04 Year 2004 | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M 1 Yes <input type="checkbox"/> No <input type="checkbox"/> | | 28c. Describe how injury occurred | |
| 28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Christopher T. McKee | | 29c. License number Res - 000 | |
| 29d. Date signed (Month, Day, Year) May 04, 2004 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher T. McKee, DO 600 N. Wolfe St. Baltimore, MD 21287 | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature [Signature] | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15171

1- For
State
Registrar

| | | | | | |
|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward Leonard Scouten | | 2. Date of Death Month Day Year April 25, 2004 | | 3. Time of Death 2:00 P^M |
| | 4a. Facility Name (If not institution, give street and number) Buckingham's Choice | | 4b. City, Town, or Location of Death Adamstown | | 4c. County of Death Frederick |
| Funeral Director | 5. Social Security Number 438-68-3066 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | 8. Date of Birth (Month, Day, Year) July 10, 1914 | 9. Birthplace (State or Foreign Country) Nebraska |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Frederick | 10c. City, Town or Location Adamstown | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 3200 Bakers Circle | | 10f. Zip Code 21710 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1941-1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educator | | 16b. Kind of Business/Industry Deaf Education | | |
| | 17. Father's Name (First, Middle, Last) Lucien Scouten | | 18. Mother's Name (First, Middle, Maiden Surname) Edith F. Mathews | | |
| | 19a. Informant's Name/Relationship (Type, Print) Eleanor P. Scouten, wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 Bakers Circle, Adamstown, MD 21710 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory | | 20c. Location - City or Town, State Smithsburg, Maryland |
| | 21. Signature of Funeral Service Licensee Ryan M. Beige | | 22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, Maryland 21701 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 Years 20 Years | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Abdominal Aortic Aneurysm Type II Diabetes Mellitus Renal Insufficiency 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 26. Place of Death (Check only one) 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Ali J. Afrookteh, MD 29c. License number D35183 29d. Date signed (Month, Day, Year) April 26, 2004 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali J. Afrookteh, MD, 300 West Ninth Street, Frederick, MD 21701 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 32. Registrar's Signature Benjamin S. Sparks | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2004 15172

| | | | | | | | |
|---|---|---|---|---|--|--|--|
| Physician / Medical Examiner | 1. Decedent's Name (First, Middle, Last) M. GWENDOLYN SPORRER | | | 2. Date of Death Month Day Year May 9 2004 | | 3. Time of Death 1:41 PM | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 216-14-4292 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) APRIL 7, 1923 |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 4102 TAYLOR AVE. APT 333 | | | 10f. Zip Code 21236 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry AT HOME | | |
| | 17. Father's Name (First, Middle, Last) JAMES BARE | | | 18. Mother's Name (First, Middle, Maiden Surname) LAVINIA HARPER | | | |
| | 19a. Informant's Name/Relationship (Type, Print) YVONNE E. SPORRER / DAUGHTER | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 19090, BALTIMORE, MD 21284 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY MEMORIAL GARDENS | | 20c. Location - City or Town, State MAY 12, '04 TIMONIUM, MD | | |
| | 21. Signature of Funeral Service Licensee Kimberly A. Spurrer | | 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 HARTFORD RD, PARKVILLE, MD 21234 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal bleeding Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Coronary Artery Disease Chronic renal insufficiency | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Spurrer M.D. | | 29c. License number RES60000 | | 29d. Date signed (Month, Day, Year) 5-9-04 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sabina Fara Z 9000 Franklin Square Drive Baltimore, MD 21237 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature [Signature] | | | | | |

Spurrer, M. Gwendolyn
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15173

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Khio Sesum

2. Date of Death

Month Day Year
5 10 2004

3. Time of Death

3:15 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2110 Dulaney Valley Rd.

4b. City, Town, or Location of Death

Timonium

4c. County of Death

BALTIMORE

5. Social Security Number

579-02-7695

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

3-23-32

9. Birthplace (State or Foreign Country)

LAOS

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2110 Dulaney Valley Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

home maker

16b. Kind of Business/Industry

at home

17. Father's Name (First, Middle, Last)

(Unknown) Li

18. Mother's Name (First, Middle, Maiden Surname)

(Unknown) Li

19a. Informant's Name/Relationship (Type, Print)

Matthew Sesum - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8507 Powhatan St., New Carrollton, MD 20784

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVANS FUNERAL CHAPEL - 5-16-04 Forest Hill, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kimberly A. Zwick

22. Name and Address of Facility

2325 YORK Rd., Timonium, MD 21093
PEACEFUL ALTERNATIVES FUNERAL+CREMATION CTR

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause of injury that initiated events resulting in death) Last

Severe 3 vessel coronary artery disease
with left main " " "Due to (or as a consequence of):
With severely impaired left ventricular
contractility. Was not a operative candidate.

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part 2. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1.

Diabetes Mellitus
Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

James Douglas Clark MD

29c. License number

D0031476

29d. Date signed (Month, Day, Year)

5/12/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Douglas Clarke, 7505 Osler Dr., Ste. 214, Towson, MD 21204.

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Beverly B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15174

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Victor Ramone Siri-Ramos

2. Date of Death

Month

Day

Year

May

07

2004

3. Time of Death

6:59

P^M

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

none

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec 8, 1946

9. Birthplace (State or Foreign Country)

Dominican Rep.

Usual Residence of Decedent

10a. State

New York

10b. County

New York

10c. City, Town or Location

New York

10d. Inside City Limits

1□Yes 2□No

10e. Street and Number

506 West 173 rd. Street

10f. Zip Code

10032

10g. Citizen of What Country?

Dominican Republic

11. Marital Status

1□Never Married 2□Married

3□Widowed 4□Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1□Yes 2□No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□Yes 2□No Specify: Dominican

Republic

14. Race - American Indian,

Black, White, etc.

Specify: Dominican

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

Pedro Jose Siri

18. Mother's Name (First, Middle, Maiden Surname)

Maria Esperanza Ramos

19a. Informant's Name/Relationship (Type, Print)

Rafael Siri Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

506 W. 173rd Street #2C N.Y. N.Y. 10032

20a. Method of Disposition

1□Burial 2□Cremation 3□Removal from State

4□Donation 5□Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Municipal Cemetery

Date

5/13/04

20c. Location - City or Town, State

Santiago, DR

21. Signature of Funeral Service Licensed

[Signature]

Mo1113

22. Name and Address of Facility

4425 Broadway N.Y.

R.G. Ortiz Funeral Home

10040

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Multiple Gunshot Wounds

Approximate Interval Between Onset and Death

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1□Yes 2□No

9□Unknown

23c. If yes, outcome of pregnancy

1□Live birth 2□Fetal death

4□Pregnant at time of death

9□Unknown

3□Ectopic pregnancy

5□Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1□Yes 2□No 3□Probably 4□Unknown

24a. Was an autopsy performed?

1□Yes 2□No

24b. Were autopsy findings available prior to completion of cause of death?

1□Yes 2□No

25. Was case referred to medical examiner?

1□Yes 2□No

Hospital:

1□Inpatient

2□ER/Outpatient

3□DOA

26. Place of Death (Check only one)

Other: 4□Nursing Home 5□Residence 6□Other (Specify)

27. Manner of Death

1□Natural

2□Accident

3□Suicide

4□Homicide

5□Pending investigation

6□Could not be determined

28a. Date of Injury

(Month, Day, Year)

5/13/04

28b. Time of Injury

1830

M

28c. Injury at Work?

1□Yes 2□No

28d. Describe how injury occurred

Subject shot

28e. Location (Street and Number or Rural Route Number, City or Town, State)

5609 S 4th Ave #203

Baltimore, MD

29a. Certifier

(Check only one)

1□Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) stated.

2□Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 08, 2004

30. Name and address of person who reported cause of death (Item 23a) (Type, Print)

J. Laron Locke M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Unpend Item #23a, pt. 11, 27 per me. G832 6/27/04 tas
Certificate of Death

Reg. No. 2004 15175

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Smith

2. Date of Death

Month 08, Day 08, Year 2004

3. Time of Death

0612A. M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-40-9438

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
January 24, 1944

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

903 Pennsylvania Avenue - Apt. 2A

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Drigin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

John E. Smith, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Irene Smith

19a. Informant's Name/Relationship (Type, Print)

Linda Smith /daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

711 N. Streepier St., Baltimore MD 21205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Carmel Cem.

Date

5-15-04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Harold P. Close Funeral Service, P.A.
209 Tessler St., Baltimore MD 21201

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Alcoholism

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 09, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODOR M. KING

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23c or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15176

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)

ALAN HOWARD SEIDMAN

2. Date of Death

Month Day Year
May 9, 2004

3. Time of Death

938 a M

4a. Facility Name (If not institution, give street and number)

7913 Brookhaven Road

4b. City, Town, or Location of Death

Windsor Mill

4c. County of Death

Baltimore

5. Social Security Number

213-64-3417

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT. 7, 1959

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

WINDSOR MILL

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7913 BROOKHAVEN ROAD

10f. Zip Code

21244

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

UNITED HOME SAVINGS - BROKER

16b. Kind of Business/Industry

MGT. BROKER CO.

17. Father's Name (First, Middle, Last)

ARTHUR

SEIDMAN

18. Mother's Name (First, Middle, Maiden Surname)

SHEILA

ANSELL

19a. Informant's Name/Relationship (Type, Print)

SHEILA SEIDMAN / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7913 BROOKHAVEN ROAD - WINDSOR MILL, MD 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MOSES MONTEFIORE CEM.

Date

5/11/2004

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Edward C. Reed

22. Name and Address of Facility

SOL LEVINSON &
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Methadone Intoxication

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Obesity

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☒ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

5/9/04

28b. Time of Injury

unknown M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

7913 Brookhaven Rd., Windsor Mill, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Alan H. Seidman

29c. License number

OCME

29d. Date signed (Month, Day, Year)

May 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. A. Ron Locke, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 11 2004

32. Registrar's Signature

Alan H. Seidman

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15177

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SIGMUND I

SACHS

2. Date of Death

Month
MayDay
7Year
2004

3. Time of Death

22 15 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

220-12-6133

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

08/24/1925

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3601 FORDS LANE #511

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

OWNER

16b. Kind of Business/Industry

TRANSPORTATION

17. Father's Name (First, Middle, Last)

WILLIAM

SACHS

18. Mother's Name (First, Middle, Maiden Surname)

ROSE

GOODMAN

19a. Informant's Name/Relationship (Type, Print)

SHIRLEY SACHS / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3601 FORDS LANE #511 BALTIMORE MD. 21215

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD VETERANS CEMETERY

Date

05/10/2004

20c. Location - City or Town, State

OWINGS MILLS MD

21. Signature of Funeral Service Licensee

Robert J. [Signature]

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD. PIKESVILLE MD 2120823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease, Atrial Fibrillation,
Diabetes, Chronic Renal Insufficiency

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an

autopsy

performed?

☐ Yes ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

☐ Yes ☒ No

25. Was case referred to medical

examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

May '7 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IK Sinai MD Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

MAY 12 2004

3. Registrar's Signature

[Signature]

State
RegistrarPatient known Sigmund I Sachs
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15178

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JULIA VIRGINIA TAPPE

2. Date of Death

May 7, 2004

3. Time of Death

3:00 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

C. J. Senior Care

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

233-03-1659

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

8. Date of Birth (Month, Day, Year)

December 3, 1903

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

145 King Street

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Walter

18. Mother's Name (First, Middle, Maiden Surname)

Charnock

Matilda

Bellville

19a. Informant's Name/Relationship (Type, Print)

Eve J. McGrory Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1217 Lindsay Lane, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematorium 05-08-04 Smithsburg, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. Joel Brady

22. Name and Address of Facility

Andrew K. Coffman Funeral Home, Inc.
40 East Antietam Street, Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death

5 MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ARTERIOSCLEROTIC CORONARY ARTERY DISEASE

10 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Assisted

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Living

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

M 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Brull MD PERSONAL PHYSICIAN

29c. License number

D0004359

29d. Date signed (Month, Day, Year)

MAY 7 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT BRULL MD 1459 POTOMAC ST. HAGERSTOWN, MD 21742

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

John B. Spivey

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15179

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) **Davida G. Task** 2. Date of Death Month **May** Day **7** Year **2004** 3. Time of Death **10:30a M**

4a. Facility Name (If not institution, give street and number) **Hebrew Home of Greater Washington** 4b. City, Town, or Location of Death **Rockville** 4c. County of Death **Montgomery**

5. Social Security Number **002-22-2681** 6. Sex ☒ M ☐ F **XX** 7. Age (In yrs. last birthday) **98** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **May 4, 1906** 9. Birthplace (State or Foreign Country) **New York**

Usual Residence of Decedent 10a. State **MD** 10b. County **Montgomery** 10c. City, Town or Location **Rockville** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **6121 Montrose Road** 10f. Zip Code **20852** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **Grade 12** College (1-4 or 5+) **4 Years** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Legal Secretary** 16b. Kind of Business/Industry **Clerical**

17. Father's Name (First, Middle, Last) **Jacob Green** 18. Mother's Name (First, Middle, Maiden Surname) **Mary Lowe**

19a. Informant's Name/Relationship (Type, Print) **Ted Task / son** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **500 King Farm Blvd. Rockville, MD 20850**

20a. Method of Disposition ☐ Burial ☐ Cremation ☒ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Crecent Burial Park** Date **May 10, 2004** 20c. Location - City or Town, State **Pennsauken, N.J.**

21. Signature of Funeral Service Licensee **[Signature]** M00969 22. Name and Address of Facility **Bershtler & Shenberg Funeral Chapels** **5341 State H. 38 West Pennsauken, N.J. 08109**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **CEREBRAL THROMBOSIS** Approximately Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐ Yes ☒ No ☐ Unknown 23c. If yes, outcome of pregnancy ☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy ☐ Pregnant at time of death ☐ Other (specify) 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **HYPERTENSION** 23e. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☐ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **[Signature]** 29c. License number **D 18084** 29d. Date signed (Month, Day, Year) **MAY 07, 2004**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **D. D. PATEL M.D. 6121 MONTROSE RD Rockville, MD 20852**

31. Date Filed (Month, Day, Year) **MAY 12 2004** 32. Registrar's Signature **[Signature]**

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DAVIDA TASK Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15180

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last) Edna Brown Turner | | 2. Date of Death Month Day Year May 1, 2004 | | 3. Time of Death 12:35 PM | |
| 4a. Facility Name (If not institution, give street and number) Bradford Oaks Nursing Home | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George's | |
| 5. Social Security Number 223-22-0997 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 10, 1919 |
| 9. Birthplace (State or Foreign Country) Virginia | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Calvert | 10c. City, Town or Location St. Leonard | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 5637 Cherry Street | | 10f. Zip Code 20735 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) Lee Brown | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Belle Brown | | |
| 19a. Informant's Name/Relationship (Type, Print) Joseph Gary Turner /Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24404 Weish Rd., Gaithersburg, MD 20882 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lael Baptist Church | | 20c. Location - City or Town, State 5/5/04 Lignum, VA | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Cloze English Funeral Home 11190 James Monroe Hwy., Culpeper, VA 22701 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE | | | | | |
| Due to (or as a consequence of): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ATHEROSCLEROSIS | | | | | |
| Due to (or as a consequence of): | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Now Hodgkins Lymphoma | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number 019471 | | 29d. Date signed (Month, Day, Year) 5/3/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank M Brown 11001 Livingston Rd #103 Ft. Washington MD 20744 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15181

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harlow

Thomas

2. Date of Death

Month

Day

Year

May

10 2004

3. Time of Death

10:34 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

237-34-0173

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
May 16, 1923

9. Birthplace (State or Foreign Country)

NC.

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7753 Charlesmont Road

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6 years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Crane Operator

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Walter Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Parker

19a. Informant's Name/Relationship (Type, Print)

Geraldine Thomas

wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7753 Charlesmont Road, Dundalk, MD. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Belair Memorial Gardens

Date

May 14, 2004

20c. Location - City or Town, State

Belair, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Five days

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Lynette Brown M.D., Ph.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

May 11, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lynette Brown, Johns Hopkins Hospital, 600 North Wolfe, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Denise B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Unpend Item #23a, 27, 28a-f per me G831 5/13/04 tas
Certificate of Death
Reg. No. 2004 15182

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Allen Thompson

2. Date of Death

May 2, 2004

3. Time of Death

0312 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

5034 Clifton Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

N/A

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

39

8. Date of Birth

03 08 65

9. Birthplace (State or Foreign Country)

NJ

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5034 Clifton Ave

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

Unk

unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

Bernard Black

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Thompson

19a. Informant's Name/Relationship (Type, Print)

Margaret Thompson-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1110 Eastern Parkway, Newark, NY 07106

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Cemetery 5/7/04

Date

20c. Location - City or Town, State

Neward, NJ

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F/H West
4300 Wabash Ave, Baltimore Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cocaine Intoxication

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Ectopic pregnancy
9 ☐ Unknown 5 ☐ Other (specify)

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) At Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☒ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Found 5/2/2004

28b. Time of Injury

Found 2:40 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State) 5034 Clifton Ave. Baltimore, Md

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Signature: [Signature]

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 3, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA RUBIO, MD

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Signature: [Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15183

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

| | | | | | |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) June E. Urbanek | | 2. Date of Death Month Day Year May 4, 2004 | | 3. Time of Death 7:30 PM | |
| 4a. Facility Name (If not institution, give street and number) 3110 Myrtle Avenue | | 4b. City, Town, or Location of Death Temple Hills | | 4c. County of Death Prince George's | |
| 5. Social Security Number 579-20-0576 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | 8. Date of Birth (Month, Day, Year) 12/23/1923 | 9. Birthplace (State or Foreign Country) Washington, DC | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Prince George's | 10c. City, Town or Location Temple Hills | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 3110 Myrtle Avenue | | 10f. Zip Code 20748 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: USA | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | |
| 16b. Kind of Business/Industry In Home | | 17. Father's Name (First, Middle, Last) Oscar M. Carter | | 18. Mother's Name (First, Middle, Maiden Surname) Louise Crawford | |
| 19a. Informant's Name/Relationship (Type, Print) Teresa Pruiett / Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6104 Union Village Dr. Clifton, Virginia 20124 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Md. Veterans Ce. | | 20c. Location - City or Town, State Cheltenham, Maryland | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIAC FAILURE Due to (or as a consequence of): CORONARY ARTERY DISEASE Due to (or as a consequence of): ATRIAL FIBRILLATION Due to (or as a consequence of): STROKE Approximate Interval Between Onset and Death Years | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number 0101047220 VA | | 29d. Date signed (Month, Day, Year) 05/10/2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Piyush R. Patel MD 13890 Braddock Road #210 Centreville, Virginia 20121 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerState
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15184

| | | | | | | | | | | | | | |
|---|--|------------------------------------|---|--|---|--|---|--|---|--|-----------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES E. WHITNEY | | | | | 2. Date of Death Month 5 Day 1 Year 04 | | 3. Time of Death 10⁵² pm | | | | | |
| | 4a. Facility Name (If not institution, give street and number) GINGER COVE | | | | | 4b. City, Town, or Location of Death ANNAPOLIS, MD | | 4c. County of Death ANNE ARUNDEL | | | | | |
| Funeral Director | 5. Social Security Number 019-14-4975 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) 4-11-21 | | 9. Birthplace (State or Foreign Country) ATTLEBORO, MASS. | | | | |
| | Usual Residence of Decedent | | | | | 10c. City, Town or Location Annapolis | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10a. State MD | | 10b. County Anne Arundel | | 10e. Street and Number 2305 River Crescent Drive | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+ | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) chemist | | | 16b. Kind of Business/Industry enviromental protection | | | | | |
| 17. Father's Name (First, Middle, Last) Earl Clifford Whitney | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elsie Billington | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) James S. Whitney/son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Fairleigh Court Tracys Landing, MD 20779 | | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | | |
| 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. PARKINSON'S DISEASE Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death 20 yrs | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. POLIO | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | |
| 29b. Signature and title of certifier WM Wade | | | | | 29c. License number 024768 | | | 29d. Date signed (Month, Day, Year) 5-5-04 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) DAIBS, WM A. 277 PEN. Farm Rd., ANNAPOLIS MD 21012 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | | 32. Registrar's Signature Brown B Sparks | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15185

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Philip Gordon Waldner

2. Date of Death

May 06 2004

3. Time of Death

11:00 pM

4a. Facility Name (If not institution, give street and number)

Gilchrist

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

212-07-6779

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

Aug. 31 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Nottingham

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7720 Bennerton Dr.

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Fire Department Chief

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Philip C. Waldner

18. Mother's Name (First, Middle, Maiden Surname)

Rose Happel

19a. Informant's Name/Relationship (Type, Print)

Mr. Scott Waldner/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 Dusty's Lane Glen Rock, Pa. 17327

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA.

Date

5-12-04

20c. Location - City or Town, State

Garrison, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic colon Cancer

Approximate Interval Between Onset and Death
years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Dr. Anthony Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

MAY 7, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.A. Riley G-BMC 6701 N. Charles St Balto. Md 21204

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

State Registrar

Thursday, May 6th 2004 @ 11PM
Baltimore, Maryland 21215-0036

WALDNER, Philip 05-06-04 @ 9300
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15186

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bessie K. Wilkins

2. Date of Death

Month
MayDay
10Year
2004

3. Time of Death

8:20 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

220-30-6417

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 24, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1000 Franklin Avenue Apt. 1207

10f. Zip Code

21221

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John J. Harvath

18. Mother's Name (First, Middle, Maiden Surname)

Pearl E. Rhoades

19a. Informant's Name/Relationship (Type, Print)

Rose Suter - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2013 Smith Avenue Baltimore, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Pk.

Date

5/14/04

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

M. P. G.

22. Name and Address of Facility

Gary L. Kaufman Funeral Home At MMP., Inc.
7250 Washington Blvd. Elkridge, Maryland 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

C.O.P.D

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

History of Smoking

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C.A.D.

Acute M.I.

Ischemic Cardiomyopathy

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Gary Friedman MD

29c. License number

D0032392

29d. Date signed (Month, Day, Year)

5/10/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Gary Friedman 9000 Franklin Square Drive, Baltimore, MD 21237

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Zane Wiatr
04-03028
RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar
Unpend Item #25a, 27, 28a-1 per me 6831 5/13/04 tas
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg. No. 2004 15187

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

| | | | | | | | | | |
|---|--|---|--|--|--------------------------------|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last) Zane Wiatr | | | | 2. Date of Death Month May Day 4 Year 2004 | | | | 3. Time of Death 0146 A M | |
| 4a. Facility Name (If not institution, give street and number) 3 Parkwood Road | | | | 4b. City, Town, or Location of Death Dundalk | | | | 4c. County of Death Baltimore | |
| 5. Social Security Number 213-76-0547 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 47 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 19, 1957 | | 9. Birthplace (State or Foreign Country) Maryland | |
| Usual Residence of Decedent | | | | | | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | | | | 10e. Street and Number 8410 Cove Road | |
| 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States | | | | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 Years College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer | | | 16b. Kind of Business/Industry Engineering | | |
| 17. Father's Name (First, Middle, Last) Walter Wiatr | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jeanette Latvanas | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Wilhelmina Watnoski / Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1239 South Clinton Street Baltimore, MD 21224 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Ht. of Mary Cem. | | Date 5/7/2004 | | 20c. Location - City or Town, State Dundalk, Maryland | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | | | |

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alcohol and Narcotic Intoxication | | | | Approximate Interval Between Onset and Death | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) At Scene | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found 5/4/04 | | 28b. Time of death Found 1:44 A M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Unknown | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found in residence | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Parkwood Road Baltimore, MD | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | | |
| 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) May 4, 2004 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15188

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

| | | | | | | |
|---|--|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) ANNE NEUMANN WAITZ | | | 2. Date of Death Month Day Year May 9, 2004 | | 3. Time of Death 9:45 A. ^M | |
| 4a. Facility Name (If not institution, give street and number) Prince Georges County Hospital Center | | | 4b. City, Town, or Location of Death Cheverly | | 4c. County of Death Prince George's | |
| 5. Social Security Number 215-16-5096 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | 8. Date of Birth (Month, Day, Year) March 19, 1918 | 9. Birthplace (State or Foreign Country) Maryland | |
| Usual Residence of Decedent | | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10a. State Maryland | | 10b. County N/A | | 10f. Zip Code 21212 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 years | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) Joseph Neumann | | | 18. Mother's Name (First, Middle, Maiden Surname) Albina Warner | | | |
| 19a. Informant's Name/Relationship (Type, Print) Amy Howell (daughter) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12603 Prospect Knolls Drive Bowie, Maryland 20720 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Carrison Forest Veterns Cem. | | 20c. Location - City or Town, State 5-13-04 Owings Mills, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular accident Due to (or as a consequence of): b. Uncontrolled Hypertension Due to (or as a consequence of): c. Coronary Artery Disease Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D0060546 | | 29d. Date signed (Month, Day, Year) 5/10/04 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nirmala Yadla, M.D. 3001 Hospital Drive Cheverly, Maryland 20785 | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.


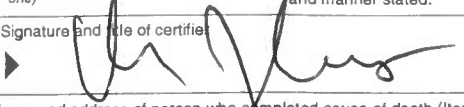

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15189

1- For
State
Registrar

| | | | | | | | |
|--|--|---|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Genevieve McGoff Windheim | | | 2. Date of Death Month Day Year May 7 2004 | | 3. Time of Death 7:00 a^M | |
| | 4a. Facility Name (If not institution, give street and number) Villa Rosa Nursing Home | | | 4b. City, Town, or Location of Death Mitchellville | | 4c. County of Death Prince Georges | |
| Funeral Director | 5. Social Security Number 485-12-3974 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 97 Yrs. | 8. Date of Birth (Month, Day, Year) June 30, 1906 | | 9. Birthplace (State or Foreign Country) Nebraska | |
| | Usual Residence of Decedent | | | 10. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Churchton | | 10d. Inside City Limits |
| | 10e. Street and Number P.O. Box 214 | | 10f. Zip Code 20733 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical | | 16b. Kind of Business/Industry Law Offices | | |
| | 17. Father's Name (First, Middle, Last) Unknown McGoff | | | 18. Mother's Name (First, Middle, Maiden Surname) Unknown | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Judith N. Beach (Niece) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 421 Hamlin Club Dr., #205, Edgewater, MD 21037 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington Nat'l Cem. | | 20c. Location - City or Town, State 6-1-2004 Arlington, VA | | |
| | 21. Signature of Funeral Service Licensee  | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Adult Failure to Thrive Due to (or as a consequence of): Dehydration Due to (or as a consequence of): Alzheimer's Due to (or as a consequence of): Heart Failure Due to (or as a consequence of): 4 yrs | | | | | | Approximate Interval Between Onset and Death 4 yrs |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D52261 | | 29d. Date signed (Month, Day, Year) 5-7-2004 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard J. Feldman MD 9500 Arundel Rd, Lahan MD 20706 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0036

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15190

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Richard P. Wallace, Sr.

2. Date of Death

Month

Day

Year

3. Time of Death

1332 P M

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice At Mercy Hospital BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

MARYLAND

5. Social Security Number

213-14-8023

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9-14-23

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1608 Rosewick Ave.

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRACTOR TRAILER DRIVER

16b. Kind of Business/Industry

Local Union # 557-

17. Father's Name (First, Middle, Last)

Peter J. Wallace

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Law

19a. Informant's Name/Relationship (Type, Print)

Richard P. Wallace, Jr-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2200 ERIN WAY, Bel Air, MD 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

5-15-04

20c. Location - City or Town, State

Rosedale, MD

21. Signature of Funeral Service Licensee

Kimberly A. Zuretta

22. Name and Address of Facility

BALTIMORE, MD 21234
EVANS FUNERAL CHAPEL, 8800 HARFORD RD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

lung cancer

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

140854

29d. Date signed (Month, Day, Year)

5/11/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David, Riseberg 301 ST. PAUL PL Baltimore 21202

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15191

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM E. WELCH

2. Date of Death

Month Day Year
May 07 2004

3. Time of Death

3:30 PM

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral
Director

5. Social Security Number

216-52-7234

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

5-1-1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5927D Western Run Dr.

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: white.15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Advertising Rep.

16b. Kind of Business/Industry

Baltimore Sun Paper

17. Father's Name (First, Middle, Last)

(Unknown)

Welch

18. Mother's Name (First, Middle, Maiden Surname)

Claire Back

19a. Informant's Name/Relationship (Type, Print)

Edwin W. Peddicord

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5927D Western Run Dr. Baltimore MD 21209

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

EVANS FUNERAL CHAPEL - 5-9-04

Date

5-9-04

20c. Location - City or Town, State

Forest Hill MD

21. Signature of Funeral Service Licensee

Kimberly A. Zimont

22. Name and Address of Facility

2325 YORK RD, TIMONIUM MD 21093

PEACEFUL ALTERNATIVES FUNERAL CREMATION CENTER

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

a. Diffuse large cell lymphoma

Due to (or as a consequence of):

b. Human immunodeficiency virus

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate

Interval Between

Onset and Death

14 months

13 years

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

Matthew P. Pipeling, M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MAY 7, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW PIPELING, M.D., 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

D. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15192

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Karen Lee Willis

2. Date of Death

Month 5 Day 10 Year 2004

3. Time of Death

11:20 AM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

213-78-1369

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12-26-58

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent:

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1709 Chesterfield Square

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white.

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE

16b. Kind of Business/Industry

NURSING

17. Father's Name (First, Middle, Last)

Harry Gordon Willis

18. Mother's Name (First, Middle, Maiden Surname)

Betty Lou Willis.

19a. Informant's Name/Relationship (Type, Print)

Paul B. Littmann

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1621 Creston Dr., Forest Hill, MD 21050

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BEL AIR
EVANS FUNERAL CHAPEL

Date

5-11-04

20c. Location - City or Town, State

Forest Hill, MD

21. Signature of Funeral Service Licensee

Kimberly L. Zawrotky

22. Name and Address of Facility

2325 YORK Rd, Timonium MD 2093
PEACEFUL ALTERNATIVES FUNERAL CREMATION CTR.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Lung cancer - metastatic

Approximate Interval Between Onset and Death

months

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. A. Riley, MD

29c. License number

025205

29d. Date signed (Month, Day, Year)

May 10, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley GMC 6701 N. Charles St. Balto. MD 21204

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, X

Gerald Whitmarsh 5/5/04 12:23 pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **AMEND ITEM #10b PER FH G831 5/12/04 SH** **Certificate of Death**

Reg. No. **2004 15193**

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Gerald A. Whitmarsh** 2. Date of Death Month **5** Day **5** Year **2004** 3. Time of Death **12:23 PM**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **Gilchrist Center** 4b. City, Town, or Location of Death **Towson** 4c. County of Death **BALTIMORE**

5. Social Security Number **044-24-0205** 6. Sex **1** M **2** F 7. Age (In yrs. last birthday) **72** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **6-14-31** 9. Birthplace (State or Foreign Country) **N. Carolina**

Usual Residence of Decedent 10a. State **MD** 10b. County **Towson** 10c. City, Town or Location **Towson** 10d. Inside City Limits **1** Yes **2** No

10e. Street and Number **9 malibu Ct.** 10f. Zip Code **21204** 10g. Citizen of What Country? **USA**

11. Marital Status **1** Never Married **2** Married **3** Widowed **4** Divorced 12. Was Decedent Ever in U.S. Armed Forces? **1** Yes **2** No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) **1** Yes **2** No Specify: 14. Race - American Indian, Black, White, etc. Specify: **white.**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12)** **College (1-4or 5+)** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Psychologist** 16b. Kind of Business/Industry **State of Maryland**

17. Father's Name (First, Middle, Last) **Louis E. Whitmarsh** 18. Mother's Name (First, Middle, Maiden Surname) **Rosella A. Smith**

19a. Informant's Name/Relationship (Type, Print) **Susan W. Bond** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **4 Minebank Ct., Towson**

20a. Method of Disposition **1** Burial **2** Cremation **3** Removal from State **4** Donation **5** Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory, or other place) **EVANS FUNERAL CHAPEL - 5- 04 FOREST HILL, MD** Date 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee **Kimberly D. Keurotary** 22. Name and Address of Facility **2325 YORK RD, TIMONIUM, MD 21093** **PEACEFUL ALTERNATIVES FUNERAL + CREMATION CTR.**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Obstructive lung disease** a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? **1** Yes **2** No **9** Unknown 23c. If yes, outcome of pregnancy **1** Live birth **2** Fetal death **3** Ectopic pregnancy **4** Pregnant at time of death **5** Other (Specify) 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **1** Yes **2** No **3** Probably **4** Unknown

24a. Was an autopsy performed? **1** Yes **2** No 24b. Were autopsy findings available prior to completion of cause of death? **1** Yes **2** No

25. Was case referred to medical examiner? **1** Yes **2** No Hospital: **1** Inpatient **2** ER/Outpatient **3** DOA Other: **4** Nursing Home **5** Residence **6** Other (Specify) **Hospice**

27. Manner of Death **1** Natural **2** Accident **3** Suicide **4** Homicide **5** Pending investigation **6** Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? **1** Yes **2** No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier **1** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **2** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier **W. A. Riley** 29c. License number **D25205** 29d. Date signed (Month, Day, Year) **MAY 5, 2004**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **W. A. Riley GBMC 6701 N. Charles St. Balto. md 21208**

31. Date filed (Month, Day, Year) **MAY 12 2004** 32. Registrar's Signature **B. Sparks**

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2004 15194
Date of Death Month Day Year
May 9 2004
Time of Death 0325 AM

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last)

Willie Whitaker

2. Date of Death

May 9 2004

3. Time of Death

0325 AM

4a. Facility Name (If not institution, give street and number)

ST AGNES HEALTHCARE

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral Director

5. Social Security Number

244-48-2836

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 28, 1936

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State Maryland

10b. County N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1814 N. Bentalou St.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Handyman

16b. Kind of Business/Industry

Private Companies

17. Father's Name (First, Middle, Last)

Alfred Whitaker

18. Mother's Name (First, Middle, Maiden Surname)

Lena Stone

19a. Informant's Name/Relationship (Type, Print) (sister)

Mrs. Laura Jackson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1700 Edmondson Ave. #324 Balto. Md. 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Carmel

Date

5/15/2004

20c. Location - City or Town, State

Dundalk, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastrointestinal Bleed

Approximate Interval Between Onset and Death

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

ur

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michelle Hengeler MD

29c. License number

D0053312

29d. Date signed (Month, Day, Year)

May 9, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle Hengeler, MD 900 caton Avenue, Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a, or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15195

1- For
State
Registrar

| | | | | | |
|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BETTY YANCEY | | 2. Date of Death Month MAY Day 10 Year 2004 | | 3. Time of Death 1323 M |
| | 4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL CENTER | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 218-22-4636 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | 8. Date of Birth (Month, Day, Year) 06 09 25 | |
| | 9. Birthplace (State or Foreign Country) North Carolina | | 10. Usual Residence of Decedent | | |
| To Be Completed by Funeral Director | 10a. State Md. | 10b. County N/A | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 56 N. Gorman Ave | | 10f. Zip Code 21223 | | 10g. Citizen of What Country? U.S.A |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietary | | 16b. Kind of Business/Industry Food Service | | |
| | 17. Father's Name (First, Middle, Last) George Cronartie | | 18. Mother's Name (First, Middle, Maiden Surname) Gracie Jenkins | | |
| | 19a. Informant's Name/Relationship (Type, Print) Patricia Toliver Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 742 Chapin Cross, Balt Md 21229 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Funeral | | 20c. Location - City or Town, State 5/17/04 Arbutus Md |
| | 21. Signature of Funeral Service Licensee [Signature] | | 22. Name and Address of Facility Harri P. Close Funeral Service, P.A. 709 Tessier St., Baltimore, MD 21201 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Approximate Interval Between Onset and Death 4 DAYS | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day Year) | | | | | |
| 28b. Time of Injury M | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | | |
| 29c. License number D0060997 | | | | | |
| 29d. Date signed (Month, Day, Year) May 10, 2004 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANA SLOANE 22 SOUTH GREENE STREET BALTIMORE, MARYLAND 21201 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | | |
| 32. Registrar's Signature [Signature] | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15196

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|---|---|--|---|--|--|--|---|--|---|---|--|---|---|-------------------------------------|---|--|--|--|--|--|---|--|--|--|---------------------------------------|--|------------------------------|--|---|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ARNOLD STEVEN ALBERT | | | | 2. Date of Death Month Day Year APRIL 24, 2004 | | | | 3. Time of Death 3:10 P M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 9217 POTOMAC SCHOOL DRIVE | | | | 4b. City, Town, or Location of Death POTOMAC | | | | 4c. County of Death MONTGOMERY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 230-74-2128 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 50 Yrs. | | 8. Date of Birth (Month, Day, Year) FEB 28, 1954 | | 9. Birthplace (State or Foreign Country) VIRGINIA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County MONTGOMERY | | 10c. City, Town or Location POTOMAC | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number 9217 POTOMAC SCHOOL DRIVE | | | | 10f. Zip Code 20854 | | | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ATTORNEY | | | | 16b. Kind of Business/Industry LAW | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) STANLEY ALBERT | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ROSLYN FORMAN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) LORI S. ALBERT/WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9217 POTOMAC SCHOOL DRIVE, POTOMAC, MARYLAND 20854 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) JUDEAN MEMORIAL GDNS | | Date 04/26/2004 | | 20c. Location - City or Town, State OLNEY, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. METASTATIC COLON CANCER Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death 2.5 YEARS</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. METASTATIC COLON CANCER Due to (or as a consequence of): | Approximate Interval Between Onset and Death 2.5 YEARS | b. Due to (or as a consequence of): | c. Due to (or as a consequence of): | d. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. METASTATIC COLON CANCER Due to (or as a consequence of): | Approximate Interval Between Onset and Death 2.5 YEARS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | d. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td>IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</td> <td>23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown</td> <td>3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify)</td> <td>23d. Date of delivery Month Day Year</td> </tr> </table> | | | | | | | | | | | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) | 23d. Date of delivery Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) | 23d. Date of delivery Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td colspan="8">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</td> <td colspan="4">23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="8"></td> <td colspan="2">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table> | | | | | | | | | | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td colspan="4">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="8">26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="4">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</td> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="4">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="8">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table> | | | | | | | | | | | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td colspan="12">29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> </tr> <tr> <td colspan="6">29b. Signature and title of certifier </td> <td colspan="2">29c. License number 10200</td> <td colspan="4">29d. Date signed (Month, Day, Year) APRIL 25, 2004</td> </tr> </table> | | | | | | | | | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | 29b. Signature and title of certifier  | | | | | | 29c. License number 10200 | | 29d. Date signed (Month, Day, Year) APRIL 25, 2004 | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | | 29c. License number 10200 | | 29d. Date signed (Month, Day, Year) APRIL 25, 2004 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DENNIS A. PRIEBAT, 110 IRVING STREET, NW, WASHINGTON, D.C. 20010 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td colspan="6">31. Date filed (Month, Day, Year) APR 27 2004</td> <td colspan="6">32. Registrar's Signature </td> </tr> </table> | | | | | | | | | | | | 31. Date filed (Month, Day, Year) APR 27 2004 | | | | | | 32. Registrar's Signature  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | | | | | 32. Registrar's Signature  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DOD: 4/24/04
Albert, Arnold
TOD: 3:10 PM

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No. 2004 15197

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jeanne Nock Andrews

2. Date of Death

April 27, 2004

3. Time of Death

11:45 A^M

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville, MD

4c. County of Death

Montgomery

5. Social Security Number

272-42-4981

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

July 11, 1946

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7701 Zulima Court

10f. Zip Code

20817

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Sylvester Nock

18. Mother's Name (First, Middle, Maiden Sumame)

Harriet Kaliszewski

19a. Informant's Name/Relationship (Type, Print)

Paul Andrews, Jr. husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7701 Zulima Court Bethesda, MD 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Comfort

Date

April 29, 2004

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

J. M. Bors

22. Name and Address of Facility

Joseph Gawler's Sons Inc.
5130 Wisconsin Ave. NW Washington, DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Kaplan

29c. License number

D35635

29d. Date signed (Month, Day, Year)

April 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan 6001 Muncaster Mill Rockville, MD 20855

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

J. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

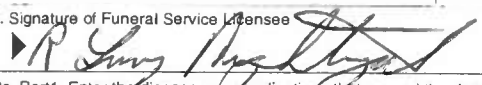

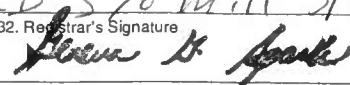
Certificate of Death

Reg. No. 2004 15198

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) RAYMOND EUGENE BARRETT | | 2. Date of Death Month April Day 24 Year 2004 | | 3. Time of Death 520 P^M |
| 4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington |
| 5. Social Security Number 220-52-7357 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 44 Yrs. | 8. Date of Birth (Month, Day, Year) 2/4/1960 | |
| 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | | | |
| Usual Residence of Decedent | | | | |
| 10a. State MD. | 10b. County WASHINGTON | 10c. City, Town or Location HAGERSTOWN | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 36 E. WASHINGTON ST. #6 | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WASTE MANAGEMENT | | 16b. Kind of Business/Industry SHOPPING CENTER | | |
| 17. Father's Name (First, Middle, Last) ROBERT WARREN BARRETT | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA MAE GREEN | | |
| 19a. Informant's Name/Relationship (Type, Print) ANNA MAE OTT - MOTHER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 442, WESTMINSTER, MD. 21158 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ALL COUNTY CREMATION 4/28/04 SYKESVILLE, MD. | | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Insufficiency Due to (or as a consequence of): b. Bilateral Pneumonia Due to (or as a consequence of): c. AIDS Due to (or as a consequence of): d. HIV Infection | | Approximate Interval Between Onset and Death Weeks Weeks Weeks Years | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute myocardial infarction. Bilateral Spontaneous Pneumothorax | | | | 23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) M | | 28b. Time of Injury 1 Yes <input type="checkbox"/> No |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier  | | 29c. License number MD D18127 | | 29d. Date signed (Month, Day, Year) 4/25/04 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. C. Smith MD 370 Mill St. Hagerstown Md 21740 | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature  | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15199

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine R. Burkart

2. Date of Death
Month Day Year
April 28, 20043. Time of Death
3:45 p M

4a. Facility Name (If not institution, give street and number)

Carroll Lutheran Village Healthcare

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

213-10-3943

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

93 Yrs.

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.8. Date of Birth
(Month, Day, Year)

June 22, 1910

9. Birthplace (State or Foreign
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

200 St. Mark Way

10f. Zip Code

21158

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Book Keeper

16b. Kind of Business/Industry

Goodyear Tire & Rubber

17. Father's Name (First, Middle, Last)

Charles H. Rutledge

18. Mother's Name (First, Middle, Maiden Surname)

Grace L. Feeney

19a. Informant's Name/Relationship (Type, Print)

Yvonne L. Brown/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12891 Mt Olivet Rd., Felton, PA 17322

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Louden Park cemetery

Date

05/03/2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Pitts Funeral Home & Chapel, P.A.

412 Washington Rd., Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Advanced Dementia - Moped

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death1 hr
5 yrs

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D37949

29d. Date signed (Month, Day, Year)

April 28th, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander Brydashenko, 245 Stumer Ave, Westminster, MD, 21157

31. Date filed (Month, Day, Year)

APR 29 2004

32. Registrar's Signature

Alex H. Smith

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15200

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth L. Bowman

2. Date of Death

Month Day Year
April 29 2004

3. Time of Death

6:15a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Prince Georges General Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

P.G.

5. Social Security Number

577-32-7971

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
10/21/1915

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3916 23rd Parkway

10f. Zip Code

20748

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Edward Langford

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Langford

19a. Informant's Name/Relationship (Type, Print)

Joseph Bowman/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3916 23rd Pkwy. Temple Hills, MD. 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cem.

Date

5/7/04

20c. Location - City or Town, State

Brentwood, MD.

21. Signature of Funeral Service Licensee

Prince Edwards

22. Name and Address of Facility

Hodges and Edward

3910 Silver Hill RD. Suitland, Md. 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS SYNDROME

Due to (or as a consequence of)

b. PROBABLE PNEUMONIA

Due to (or as a consequence of)

c. CEREBRAL VASCULAR ACCIDENT

Due to (or as a consequence of)

d. HYPERTENSION

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEHYDRATION

ANEMIA

CONGESTIVE HEART FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Shervin Tahmani

29c. License number

D54140

29d. Date signed (Month, Day, Year)

4/29/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR SHERVIN TAHMANI

3001 HOSPITAL DR

CHEVERLY, MD 20785

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- Amend Item #22, per FH/Dr, G851, 5/12/2004, gap

Certificate of Death

Reg. No. 2004 15201

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Charles Blackwell | | 2. Date of Death Month Day Year May 3, 2004 | | 3. Time of Death 17:10 M | |
| 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death P.G. | |
| 5. Social Security Number 578-56-9881 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday) 61 Yrs. | 8. Date of Birth (Month, Day, Year) 8/8/1942 | 9. Birthplace (State or Foreign Country) Wash.D.C. | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County P.G. | 10c. City, Town or Location District Heights | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 2203 Marbury Dr. | | 10f. Zip Code 20747 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician | | 16b. Kind of Business/Industry Private | | | |
| 17. Father's Name (First, Middle, Last) Richard Blackwell | | 18. Mother's Name (First, Middle, Maiden Surname) Mildred Tilghman | | | |
| 19a. Informant's Name/Relationship (Type, Print) Shelley Hardy/daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2905 Mighty Oak Pl. Waldorf Md. 20603 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park | | 20c. Location - City or Town, State Landover, Md. | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Hodges and Edwards Funeral Home 3910 Silver Hill Road, Suitland, Maryland 20746 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. subarachnoid bleed Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Unknown Unknown | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Large Hemorrhagic infarct | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Rointon Farahifar M.D. | | 29c. License number D43446 | | 29d. Date signed (Month, Day, Year) 5/4/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROINTAN FARAHIFAR MD 9801 Georgia Ave Suite 3-41 Silver Spring MD 20902 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15202

1- For
State
Registrar

| | | | | | | | | |
|--|--|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) PHILIP I. BROWN | | | | 2. Date of Death Month Day Year APRIL 21, 2004 | | 3. Time of Death 7:07 A ^M | |
| | 4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL | | | | 4b. City, Town, or Location of Death BETHESDA | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 149-05-7882 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) MAY 14, 1921 | |
| | 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | 10a. State MARYLAND | | 10b. County MONTGOMERY | | 10c. City, Town or Location BETHESDA | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 5450 WHITLEY PARK TERRACE, APT. 412 | | 10f. Zip Code 20814 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STATISTITIAN | | 16b. Kind of Business/Industry CONSULTING | | | |
| | 17. Father's Name (First, Middle, Last) JOSEPH BROWN | | | | 18. Mother's Name (First, Middle, Maiden Surname) SELMA HYMAN | | | |
| | 19a. Informant's Name/Relationship (Type, Print) LILIANA BROWN/WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5450 WHITLEY PARK TERRACE, APT. 412, BETHESDA, MD 20814 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEM. GDNS. | | 20c. Location - City or Town, State FALLS CHURCH, VIRGINIA | | 20d. Date 04/22/2004 | |
| | 21. Signature of Funeral Service Licensee Amanda Gudewig | | 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 10 days | | | | | |
| | 23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia, acute renal failure, Respiratory failure, coagulopathy | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | |
| 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Dr. Sharon Turban M.D. | | 29c. License number D56439 | | 29d. Date signed (Month, Day, Year) 04/21/2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sharon Turban 9901 Medical Center Drive, Rockville, MD 20850 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature B Sparks | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15203

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND C. BURGER

2. Date of Death

Month Day Year
APRIL 22 2004

3. Time of Death

22:00 M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

300 22 3694

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 27, 1929

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3420 North High Street

10f. Zip Code

20832

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dentist

16b. Kind of Business/Industry

Dentistry

17. Father's Name (First, Middle, Last)

Albert Burger

18. Mother's Name (First, Middle, Maiden Surname)

Clara Poete

19a. Informant's Name/Relationship (Type, Print)

Ann W. Burger / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3420 North High Street, Olney, Maryland 20832

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crem.

Date

4/23/04

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

Muriel H. Barber Funeral Home
P. O. Box 5038, Laytonsville, Md. 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sigmoid Volvulus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
5 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery disease
Peripheral Vascular disease
Cerebral Vascular disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Arthur Woodward

29c. License number

024190

29d. Date signed (Month, Day, Year)

April 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arthur Woodward 3416 Oakwood Ct Olney Maryland 20832

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15204

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel Hall Bere

2. Date of Death

Month Day Year
April 23, 2004

3. Time of Death

6:50P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Manor Care-Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

5. Social Security Number

260-40-5617

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 5, 1910

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10413 Gary Road

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James M. Hall

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Sebrell

19a. Informant's Name/Relationship (Type, Print)

James M.H. Gregg/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10413 Gary Road, Potomac, Maryland 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Montgomery
Crematorium, Inc.

Date

April 26,
2004

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Chronic Lymphocytic Leukemia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death
10 Years

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia of Alzheimer's Type

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D0053615

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aruna S. Nathan, M.D. 11125 Rockville Pike, #208, Rockville, Maryland 20852-3142

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15205

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Teresa L. Bowen

2. Date of Death

April 25, 2004

3. Time of Death

3:15 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

218-66-4081

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 9, 1955

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11404 Channing Drive

10f. Zip Code

20902

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Edward R. Bowen

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Kidwell

19a. Informant's Name/Relationship (Type, Print)

Edward R. Bowen/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14A Parkway Rd., Greenbelt, Maryland 20770

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

April 30, 2004

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Robert A. Pumphrey

MO1353

22. Name and Address of Facility
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Pneumothorax

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Drug Abuse

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carl I. Margolis (One)

29c. License number

D15236

29d. Date signed (Month, Day, Year)

April 29, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carl I. Margolis, M.D. 11125 Rockville Pike, #211, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 1, 29C, 30

State of Maryland / Department of Health and Mental Hygiene

Cecil Co. 1- For State Registrar KP 4/28/04

Certificate of Death

Reg. No.

2004 15206

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM ALPHONSO CAMPBELL

2. Date of Death

Month Day Year
APRIL 25 2004

3. Time of Death

11:27 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

243-74-5932

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 30, 1947

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

53 E. Bel Air Avenue

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Cab Driver

16b. Kind of Business/Industry

Cab Company

17. Father's Name (First, Middle, Last)

Milton Campbell

18. Mother's Name (First, Middle, Maiden Surname)

Willie Mae Leazer

19a. Informant's Name/Relationship (Type, Print)

Robert Campbell / brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

124 E. Mill Ave., Capital Heights, MD 20743

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oakwood Cemetery

Date

5/3/04

20c. Location - City or Town, State

Salisbury, NC

21. Signature of Funeral Service Licensee

Lisa Scott

22. Name and Address of Facility

Lisa Scott Funeral Home, P.A.

552 Lewis Street, Havre de Grace, MD 21078

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. MULTI SYSTEM ORGAN FAILURE

Due to (or as a consequence of):

b. CRYPTOCOCCAL MENINGITIS

Due to (or as a consequence of):

c. CHRONIC IMMUNOSUPPRESSION

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cynthia L. Pena, MD

29c. License number

P16635

29d. Date signed (Month, Day, Year)

APRIL 25, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia L. Pena, MD 22 S. Greene Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

1 APR 28 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15207

1- For
State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, 7P

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Helen Marie Calm | | 2. Date of Death Month April Day 28 , Year 2004 | | 3. Time of Death 1:30 a M | |
| 4a. Facility Name (If not institution, give street and number) Residence 1300 Apple Ridge Court | | 4b. City, Town, or Location of Death Edgewood | | 4c. County of Death Harford | |
| 5. Social Security Number 213-46-3827 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 88 Yrs. | 8. Date of Birth (Month, Day, Year) May 15, 1915 | | 9. Birthplace (State or Foreign Country) Pennsylvania |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Harford | 10c. City, Town or Location Edgewood | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1300 Apple Ridge Court | | 10f. Zip Code 21040 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Twelve Years College (1-4or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Personal Residence | | | |
| 17. Father's Name (First, Middle, Last) James S. Stewart | | | 18. Mother's Name (First, Middle, Maiden Sumame) Ella Mae Halliger | | |
| 19a. Informant's Name/Relationship (Type, Print) Jean Hockaday (daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 Apple Ridge Court, Edgewood, Maryland 21040 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Berkley Cemetery | | 20c. Location - City or Town, State Darlington, Maryland | |
| 21. Signature of Funeral Service Licensee Thomas M. Patterson, Sr. | | 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | Approximate Interval Between Onset and Death |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier T. Brando MD | | 29c. License number 042800 | | 29d. Date signed (Month, Day, Year) 4/28/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Brando 319 S Union Ave, Hw6, Md, 21078 | | | | | |
| 31. Date filed (Month, Day, Year) APR 29 2004 | | 32. Registrar's Signature [Signature] | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15208

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Lottie Calkins

2. Date of Death

May 1, 2004

3. Time of Death

1:40 A M

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

080-03-6413

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 13, 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

317 Garner Avenue

10f. Zip Code

20602

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Hamilton Vanderveer

18. Mother's Name (First, Middle, Maiden Surname)

Millie Cornell

19a. Informant's Name/Relationship (Type, Print)

Jean M. Silva - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

317 Garner Avenue, Waldorf, MD 20602

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

White Marsh Mem. Pk

Date

5-10-04

20c. Location - City or Town, State

Ambler, PA

21. Signature of Funeral Service Licensee

M01341

22. Name and Address of Facility

Huntt Funeral Home
P. O. Box 156, Waldorf, MD 2060423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. LOW CARDIAC OUTPUT

Due to (or as a consequence of):

b. LEFT VENTRICULAR DYSFUNCTION

Due to (or as a consequence of):

c. MYOCARDIAL ISCHEMIA

Due to (or as a consequence of):

d. CORONARY ARTERY DISEASE

Approximate
Interval Between
Onset and Death

WEEKS

YEARS

YEARS

YEARS

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death
☐ Pregnant at time of death
☐ Unknown☐ Ectopic pregnancy
☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE COAGULOPATHY

SEVERE AORTIC STENOSIS

RENAL FAILURE

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an
autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samir Neimat, MD.

29c. License number

D 18551

29d. Date signed (Month, Day, Year)

5/1/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMIR NEIMAT, MD. 7610 CARROLL AV., TAKOMA PARK, MD, 20912

31. Date filed (Month, Day, Year)

MAY 04 2004

32. Registrar's Signature

Samir Neimat

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene


Certificate of Death

Reg. No. 2004 15209

1- For State Registrar

Physician / Medical Examiner

Funeral Director



| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Chester Merle Cartzendafner | | | | 2. Date of Death Month May Day 3 Year 2004 | | 3. Time of Death 1712 M | |
| 4a. Facility Name (If not institution, give street and number) 5313 Taneytown Pike | | | | 4b. City, Town, or Location of Death Taneytown | | 4c. County of Death Carroll County | |
| 5. Social Security Number 216-10-8222 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) June 17 1918 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Carroll County | | 10c. City, Town or Location Taneytown | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 5313 Taneytown Pike | | | | 10f. Zip Code 21787 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) route salesman | | 16b. Kind of Business/Industry bakery | |
| 17. Father's Name (First, Middle, Last) Jesse Cartzendafner | | | | 18. Mother's Name (First, Middle, Maiden Surname) Flora Bell Angell | | | |
| 19a. Informant's Name/Relationship (Type, Print) Joan Champagne / daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Laurel Court Nashua, New Hampshire 03062 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Pleasant Cemetery | | Date May 7, 2004 | | 20c. Location - City or Town, State Taneytown, Maryland | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787 | | | |

To Be Completed by Funeral Director

| | | | | | |
|--|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCVD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death minutes | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |

| | | | | | |
|---|--|---|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

| | | | | | |
|---|--|--|--|--|--|
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |

| | | | | | |
|--|--|--|--|---|--|
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier.  | | 29c. License number 00051924 | | 29d. Date signed (Month, Day, Year) May 4, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herbert P. Henderson 500 2673 Manchester Rd Manchester MD 21102 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature  | | | |

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15210

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara Jean Cashman

2. Date of Death

April 23, 2004

3. Time of Death

9:55P. M

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

213-24-0220

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 18, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4509 Yucca Street

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Furniture Warehouse

17. Father's Name (First, Middle, Last)

Charles Roscoe Strausburg

18. Mother's Name (First, Middle, Maiden Surname)

Nettie Mae Cartridge

19a. Informant's Name/Relationship (Type, Print)

Diane M. Costello-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4509 Yucca Street Beltsville, Maryland 20705

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Meadowridge Memorial Park

Date

4/27/2004

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Severe Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Acute Diverticulitis

Due to (or as a consequence of):

d. Descending ulcer

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Left lung carcinoma; Aortic Aneurysm;

Severe Osteoporosis

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D013687

29d. Date signed (Month, Day, Year)

April 24, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joselito Magday, M.D. 11701 Roby Avenue Beltsville, Maryland 20705

State
Registrar

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15211

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|--|--|--|---|---|---|---------------------------------|--------------------------------|--|--|-----------------------------------|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Raymundo Chavarria | | | | 2. Date of Death Month Day Year April 19 2004 | | | | 3. Time of Death 12:26 AM | | | | | |
| | 4a. Facility Name (If not institution, give street and number) UMMC | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | | | | |
| Funeral Director | 5. Social Security Number 217-06-5514 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 41 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) 6/29/1962 | | 9. Birthplace (State or Foreign Country) Nicaragua | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Prince George's | | 10c. City, Town or Location Riverdale | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| | 10e. Street and Number 5610 Patterson Road | | | | 10f. Zip Code 20737 | | | | 10g. Citizen of What Country? Nicaragua | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Nicaraguan | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unemployed | | | | 16b. Kind of Business/Industry none | | | | | |
| | 17. Father's Name (First, Middle, Last) Bartolome Chavarria | | | | 18. Mother's Name (First, Middle, Maiden Surname) Silvia Elena Chavarria | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Celmira Mutts/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5610 Patterson Road Riverdale, Md 20737 | | | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crem. | | | | 20c. Location - City or Town, State 4/27/04 Beltsville, Md | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility PHILIP D. RINALDI FUNERAL SERVICE P.A. 9241 Columbia Blvd. Silver Spring, Md 20910 | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number AU4176435015124 | | | | 29d. Date signed (Month, Day, Year) April 19, 2004 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abena Osei-Wusu, Dept of Internal Medicine UMMC, 22 S. Greene St Balto, MD 21201 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | | | 32. Registrar's Signature | | | | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15212

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SHIRLEY

COHEN

2. Date of Death

Month Day Year
APRIL 28, 2004

3. Time of Death

10:15 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

060-34-4017

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10/19/1904

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6111 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

BENJAMIN

TULIPAN

18. Mother's Name (First, Middle, Maiden Surname)

ANNA

GREEN

19a. Informant's Name/Relationship (Type, Print)

HELENE TULLO/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 FERN STREET, BEVERLY, MA 01915

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

UNITED HEBREW CEMETERY 05/02/2004 STATEN ISLAND, NEW YORK

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Amanda Gudewig

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregory A. Compton MD

29c. License number

D24942

29d. Date signed (Month, Day, Year)

April 29 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORY A. COMPTON MD 6121 Montrose Rd Rockville, MD

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15213

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Francis Joseph Collins, Jr. | | 2. Date of Death Month Day Year April 26, 2004 | | 3. Time of Death 3:38 P M | |
| 4a. Facility Name (If not institution, give street and number) 1844 Greenplace Terrace | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| 5. Social Security Number 215-36-3305 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday) 65 Yrs. | |
| 8. Date of Birth (Month, Day, Year) Sept. 25, 1938 | | 9. Birthplace (State or Foreign Country) Washington, DC | | | |
| 10a. State Florida | | 10b. County Pinellas | | 10c. City, Town or Location Clearwater | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1560 Gulf Boulevard, #907 | | 10f. Zip Code 33767 | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1960-62 | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Funeral Director/Owner | | 16b. Kind of Business/Industry Funeral Service | |
| 17. Father's Name (First, Middle, Last) Francis Joseph Collins, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Agnes Catharine Murphy | | | |
| 19a. Informant's Name/Relationship (Type, Print) Maureen Collins McHugh/Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1844 Greenplace Terrace, Rockville, Maryland 20850 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery | | 20c. Location - City or Town, State Washington, DC | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Prostate Cancer | | 23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23c. Date of delivery Month Day Year | |
| 23d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23f. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 23g. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24a. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Sister's Residence | |
| 24c. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 24d. Date of Injury (Month, Day Year) | | 24e. Time of Injury M | |
| 24f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 24g. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24h. Describe how injury occurred | |
| 24i. Location (Street and Number or Rural Route Number, City or Town, State) | | 24j. Date signed (Month, Day, Year) April 28, 2004 | | 24k. License number D0011921 | |
| 24l. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Galotto M.D. 5225 Pooks Hill Road, Suite 1A, Bethesda, MD, 20814 | | 24m. Date filed (Month, Day, Year) APR 30 2004 | | 24n. Registrar's Signature  | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For AMEND#8 per INF5/7/04, BW, McCo
State Registrar AMEND#26 per MD4/27/04, BW, McCo

Certificate of Death

Reg. No.

2004 15214

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Maria A. Cortez | | 2. Date of Death Month Day Year April 19, 2004 | | 3. Time of Death 9:15 PM | |
| 4a. Facility Name (If not institution, give street and number) 13914 Bauer Court | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| 5. Social Security Number 579-04-0603 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | |
| 8. Date of Birth (Month, Day, Year) Nov. 14, 1918 | | 9. Birthplace (State or Foreign Country) El Salvador | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 2314 Glenmont Circle, Apt. T-7 | | 10f. Zip Code 20902 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Salvadoran | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) Isabel Benitez | | 18. Mother's Name (First, Middle, Maiden Surname) Martina Flores | | | |
| 19a. Informant's Name/Relationship (Type, Print) Rita Cardenas/ Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 Allison Street, Brentwood, MD 20722 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Memorial Park | | 20c. Location - City or Town, State Laurel, Maryland | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreatic Carcinoma Due to (or as a consequence of): Liver (Hepatic) Carcinoma Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | |
| Approximate Interval Between Onset and Death 4 months | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | | |
| 23d. Date of delivery Month Day Year | | | | | |
| Part 4. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Hypertension | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) daughter's residence | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number 044826 | | 29d. Date signed (Month, Day, Year) 4/21/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shelly Williams M.D. 1109 Spring Street, #201, Silver Spring, MD 20910 | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar
2- For Medical Examiner
3- For Funeral Director
4- For Coroner
5- For Medical Examiner
6- For Medical Examiner
7- For Medical Examiner
8- For Medical Examiner
9- For Medical Examiner
10- For Medical Examiner
11- For Medical Examiner
12- For Medical Examiner
13- For Medical Examiner
14- For Medical Examiner
15- For Medical Examiner
16- For Medical Examiner
17- For Medical Examiner
18- For Medical Examiner
19- For Medical Examiner
20- For Medical Examiner
21- For Medical Examiner
22- For Medical Examiner
23- For Medical Examiner
24- For Medical Examiner
25- For Medical Examiner
26- For Medical Examiner
27- For Medical Examiner
28- For Medical Examiner
29- For Medical Examiner
30- For Medical Examiner
31- For Medical Examiner
32- For Medical Examiner

Certificate of Death

Reg. No. 2004 15215

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|--|--|--|--------------------------------|---|
| 1. Decedent's Name (First, Middle, Last) George S. Craver | | | 2. Date of Death Month Day Year April 26 2004 | | 3. Time of Death 1:35 A M |
| 4a. Facility Name (If not institution, give street and number) Renaissance Garden at Riderwood Village | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Prince Georges Montgomery |
| 5. Social Security Number 579-18-9268 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 1, 1918 |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | |

| | | | | |
|-------------------------------|--|----------------------------------|---|--|
| 10a. State Maryland | | 10b. County Montgomery | 10c. City, Town or Location Silver Spring | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|-------------------------------|--|----------------------------------|---|--|

| | | | |
|---|--|-------------------------------|---|
| 10e. Street and Number 3124 Gracefield Road, #119 | | 10f. Zip Code 20904 | 10g. Citizen of What Country? USA |
|---|--|-------------------------------|---|

| | | | | | |
|--|--|---|--|--|--|
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | | | | 14. Race - American Indian, Black, White, etc. Specify: White | |

| | | | | | |
|---|--|---|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber/ Welder | | 16b. Kind of Business/Industry Department of the Navy | |
|---|--|---|--|---|--|

| | | | |
|---|--|---|--|
| 17. Father's Name (First, Middle, Last) George Simon Craver | | 18. Mother's Name (First, Middle, Maiden Surname) Nellie Dailey | |
|---|--|---|--|

| | | | |
|---|--|---|--|
| 19a. Informant's Name/Relationship (Type, Print) Hope W. Craver/ Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3124 Gracefield Road, #119, Silver Spring, MD 20904 | |
|---|--|---|--|

| | | | | | |
|---|--|--|--|--|--|
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Carmel Cemetery | | 20c. Location - City or Town, State Sunshine, Maryland | |
| 20d. Date April 28, 2004 | | | | | |

| | | | |
|--|--|--|--|
| 21. Signature of Funeral Service Licensee John E. Parker | | 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 | |
|--|--|--|--|

| | | | |
|--|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia | | Approximate Interval Between Onset and Death 3 days | |
|--|--|---|--|

| | | | |
|--|--|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Advanced Dementia | | Approximate Interval Between Onset and Death 2 years | |
|--|--|--|--|

| | | | |
|----------------------------------|--|--|--|
| Due to (or as a consequence of): | | | |
| Due to (or as a consequence of): | | | |
| Due to (or as a consequence of): | | | |
| Due to (or as a consequence of): | | | |

| | | | | | |
|---|--|---|--|---|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
|---|--|---|--|---|--|

| | | | |
|---|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
|---|--|--|--|

| | | | |
|---|--|--|--|
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
|---|--|--|--|

| | | | |
|---|--|--|--|
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
|---|--|--|--|

| | | | | | |
|---|--|---|--|-----------------------------------|--|
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |

| | | | |
|--|--|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
|--|--|--|--|

| | | | | | |
|---|--|--|--|--------------------------------------|--|
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Loveen Puthumana, MD | | 29c. License number D59524 | |
| | | 29d. Date signed (Month, Day, Year) April, 26, 2004 | | | |

| | |
|---|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVEEN PUTHUMANA 3110 GRACEFIELD ROAD, SILVER SPRING, MD 20904 | |
|---|--|

| | | | |
|---|--|--|--|
| 31. Date filed (Month, Day, Year) APR 28 2004 | | 32. Registrar's Signature Sparks | |
|---|--|--|--|

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15216

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SUSAN L. CARPENTER

2. Date of Death
Month Day Year

April 24, 2004

3. Time of Death

2305 M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

213-42-0228

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 23, 1943

9. Birthplace (State or Foreign Country)

CT

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

ST. MICHAELS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7308 DRUM POINT RD

10f. Zip Code

21663

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
016a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

REGINALD M. LEWIS

18. Mother's Name (First, Middle, Maiden Surname)

ALICE VAUX

19a. Informant's Name/Relationship (Type, Print)

MARGARET C. GOWE/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9803 TILGHMAN ISLAND RD., MCDANIEL, MD 21647

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHESAPEAKE CREMATION CTR 4-29-2004 STEVENSVILLE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M. E. Newnam C.F.S.P.

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

60 hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

20 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type 2 Diabetes

Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Timothy J. Snierek MD

29c. License number

D53253

29d. Date signed (Month, Day, Year)

4-26-04

30. Name and address of person who completed certificate of death (Item 23a) (Type, Print)

Timothy J. Snierek MD 136 Lednum Ave Preston, MD 21655

31. Date filed (Month, Day, Year)

APR 29 2004

32. Registrar's Signature

S. S. Snierek

ORIGINAL

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2004 15217

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDGAR FREDERICK CARNEAL

2. Date of Death

Month
MayDay
2Year
2004

3. Time of Death

1120

M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

220-20-2547

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
DEC. 24, 1928

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

QUEEN ANNE'S

10c. City, Town or Location

CENTREVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

820 WRIGHTS NECK ROAD

10f. Zip Code

21617

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4or 5+)
-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DISTRICT MANAGER

16b. Kind of Business/Industry

B.P.OIL

17. Father's Name (First, Middle, Last)

HORACE ELLSWORTH CARNEAL

18. Mother's Name (First, Middle, Maiden Surname)

RUTH CARROLL

19a. Informant's Name/Relationship (Type, Print)

HELEN D. CARNEAL/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

820 WRIGHTS NECK ROAD, CENTREVILLE, MD 21617

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESTERFIELD CEMETERY

Date

5-6-2004

20c. Location - City or Town, State

CENTREVILLE, MD

21. Signature of Funeral Service Licensee

James K. Helffenbein

22. Name and Address of Facility

FELLOWS, HELFFENBEIN & NEWMAN FUNERAL HOME, P.A.
408 S. LIBERTY ST., CENTREVILLE, MD 21617

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Gastric Cancer

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death
1 day

1 week

6 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D0051132

29d. Date signed (Month, Day, Year)

5-2-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JORGE ABREGO, M.D., 598 CYNWOOD DRIVE, SUITE 104, EASTON, MD 21601

31. Date filed (Month, Day, Year)

MAY - 4 2004

32. Registrar's Signature

James K. Helffenbein

State
RegistrarCARNEAL, EDGAR
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15218

1- For State Registrar

| | | | | | | | | |
|---|--|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert Chester DeShong | | | | 2. Date of Death Month Day Year April 21, 2004 | | 3. Time of Death 6:10 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 13122 Pecktonville Road | | | 4b. City, Town, or Location of Death Big Pool | | 4c. County of Death Washington | | |
| Funeral Director | 5. Social Security Number 172-24-9366 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 74 Yrs. | 8. Date of Birth (Month, Day, Year) December 12, 1929 | | 9. Birthplace (State or Foreign Country) PA | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Washington | 10c. City, Town or Location Big Pool | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 13122 Pecktonville Road | | | 10f. Zip Code 21711 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Correctional Officer | | | 16b. Kind of Business/Industry State Government | | |
| | 17. Father's Name (First, Middle, Last) Chester DeShong | | | | 18. Mother's Name (First, Middle, Maiden Surname) Melva DeShong | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Janet D. DeShong/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13122 Pecktonville Road Big Pool, MD 21711 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkhead Cemetery | | Date 04/24/04 | | 20c. Location - City or Town, State Big Pool, MD | |
| | 21. Signature of Funeral Service licensee | | | | 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Squamous cell carcinoma of parotid gland Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Phil Hamdan MD | | | | 29c. License number D46473 | | 29d. Date signed (Month, Day, Year) 04/28/04 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hind Hamdan, MD, 1130 OPAL CT., Hagerstown, MD 21740. | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature Dawn S. Spivey | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15219

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carolyn R Davis

2. Date of Death

Month Day Year
4 - 25 - 2004

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

College View Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

213-44-4347

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10-15-1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

700 Toll House Drive

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Samuel Thompson

18. Mother's Name (First, Middle, Maiden Surname)

Harriett Swailes

19a. Informant's Name/Relationship (Type, Print)

Frank Davis, Jr - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8611 A-Baltimore Natl Pike Middletown, MD 21769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lincoln Park Cem

Date

4/30/2004 Rockville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Snowden Funeral Home PA

246 N. Washington St Rockville, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

Pneumonia

Approximate
Interval Between
Onset and Death

1 Day

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Stroke

peripheral vascular Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

5th Hiren

29c. License number

D51643

29d. Date signed (Month, Day, Year)

4/25/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GSC Thomas Thompson Dr Frederick MD 21702

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

Jennifer A Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

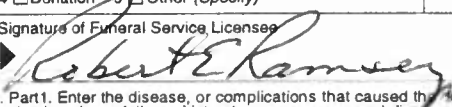
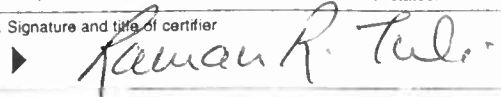
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15220

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) August Frank DeLuca, Sr. | | | 2. Date of Death Month Day Year April 22, 2004 | | 3. Time of Death 8:30 a.m. | | |
| 4a. Facility Name (If not institution, give street and number) Springbrook Adventist Nursing & Rehab. | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | | |
| 5. Social Security Number 212-09-1137 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 26, 1917 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 10613 Shady Circle | | | 10f. Zip Code 20903 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/ Operator | | 16b. Kind of Business/Industry Service Station | | |
| 17. Father's Name (First, Middle, Last) Frank DeLuca | | | 18. Mother's Name (First, Middle, Maiden Surname) Ninfa Pondolfina | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Frank C. DeLuca, Sr./ Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10515 Sweetbriar Parkway, Silver Spring, MD 20903-1238 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date April 26, 2004 | | 20c. Location - City or Town, State Silver Spring, MD | |
| 21. Signature of Funeral Service Licensee  | | | 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| Approximate Interval Between Onset and Death Less than 1 Week Less than 1 Week | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal Disease | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D19609 | | 29d. Date signed (Month, Day, Year) April 23, 2004 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman R. Tuli M.D. 10810 Darnestown Road, Suite 202, Gaithersburg, MD 20878 | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature  | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15221

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Victor Simon Deskin

2. Date of Death

Month Day Year
April 23, 2004

3. Time of Death

11:15pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

220-60-5919

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 19, 1952

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

804 Maple Avenue

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Automobile

17. Father's Name (First, Middle, Last)

Martin Deskin

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Holman

19a. Informant's Name/Relationship (Type, Print)

Margaret Deskin (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

804 Maple Avenue, Rockville, MD 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Resthaven Cemetery

Date

4/28/2004

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home
10 East Deer Park Drive
Gaithersburg, MD 2087723a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Intracranial Hemorrhage

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
24 Hours

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

d0057581

29d. Date signed (Month, Day, Year)

25 Apr 04 1455

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Miller, MD 16220 Frederick Road #213, Gaithersburg, MD 20879

State
Registrar

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15222

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lorine Wyatt

Douglas

2. Date of Death

April 24, 2004

3. Time of Death

12:28P^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

4 Pinecrest Court

4b. City, Town, or Location of Death

Greenbelt

4c. County of Death

Prince George's

5. Social Security Number

032-12-8347

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Aug. 27, 1911

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State
Kentucky

10b. County

McCracken

10c. City, Town or Location

Paducah

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3587 Clinton Road

10f. Zip Code

42001

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
5+16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Henry Clint Wyatt

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Owsley

19a. Informant's Name/Relationship (Type, Print)

Carolyn Larkin -Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Pinecrest Court Greenbelt, Maryland 20770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mount Pleasant Cemetery 4/29/2004 Puryear, Tennessee

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Metastatic Oropharyngeal Carcinoma

Approximate
Interval Between
Onset and Death

1 year

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

David Granite, MD

29c. License number

D17572

29d. Date signed (Month, Day, Year)

4/25/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Granite, MD 115 Centerway Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

B Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15223

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Genevieve Joan Drew

2. Date of Death

Month Day Year
April 22, 2004

3. Time of Death

10:05 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3221 Regina Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

215-36-3393

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Feb. 21, 1938

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3221 Regina Drive

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

Carl H. Roeder

18. Mother's Name (First, Middle, Maiden Surname)

Cecil M. Templin

19a. Informant's Name/Relationship (Type, Print)

Barrington Drew/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3221 Regina Drive, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

April 27, 2004

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

J. Kay Stiles

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Advanced Metastatic Squamous Cell Cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Asim Amin M.D.

29c. License number

D30186

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Asim Amin M.D. 3800 Reservoir Road, NW, Washington, DC 20007-2113

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Beverly B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23c or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15224

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JASON LEE DUNHAM

2. Date of Death

Month Day Year
APR 22 2004

3. Time of Death

4:42 P M

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

134-66-0526

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

22 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 10, 1981

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

NY

10b. County

ALLEGANY

10c. City, Town or Location

ALLEGANY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3857 KNIGHTS CREEK RD.

10f. Zip Code

14880

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Date 2000-2004

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

U.S. MARINE

16b. Kind of Business/Industry

DEFENSE

17. Father's Name (First, Middle, Last)

DANIEL K. DUNHAM

18. Mother's Name (First, Middle, Maiden Surname)

NATALIE JEAN WALKER

19a. Informant's Name/Relationship (Type, Print)

DANIEL K. DUNHAM/FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3857 KNIGHTS CREEK RD., ALLEGANY, NY 14880

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FAIRLAWN CEMETERY

Date

5-1-2004

20c. Location - City or Town, State

SCIO, NY

21. Signature of Funeral Service Licensee

H. W. Chambers M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PENETRATING SHRAPNEL WOUND OF HEAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death
☐ Pregnant at time of death ☐ Ectopic pregnancy
☐ Unknown ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☒ Homicide

28a. Date of Injury (Month, Day, Year)

APR 14 2004

28b. Time of Injury

1220

28c. Injury at Work?

☒ Yes ☐ No

28d. Describe how injury occurred

DURING MILITARY OPERATIONS

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

BATTLEFIELD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

AL ANBAR PROVINCE

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Tan Nguyen

29c. License number

(NY) 227359

29d. Date signed (Month, Day, Year)

APRIL 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DZUY TAN NGUYEN, MAJ, USAF, MC

ARMED FORCES INSTITUTE OF PATHOLOGY

1413 RESEARCH BLVD., ROCKVILLE MD 20850

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

amend item#5, QACHD,
per inf, 5/6/04, kk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15225

| | | | | | | | | |
|--|--|--|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERTA M. DOAK | | | | 2. Date of Death Month APRIL Day 28 Year 2004 | | 3. Time of Death 4:30 A^M | |
| | 4a. Facility Name (If not institution, give street and number) ANNAPOLITAN ASSISTED LIVING | | | | 4b. City, Town, or Location of Death ANNAPOLIS | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 579-40-1189 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) APR. 29, 1923 | |
| | 9. Birthplace (State or Foreign Country) KENTUCKY | | 10a. State MD | | 10b. County QUEEN ANNE'S | | 10c. City, Town or Location GRASONVILLE | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1115 OYSTER COVE DRIVE | | 10f. Zip Code 21638 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOMEMAKER | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry OWN HOME | | | | |
| 17. Father's Name (First, Middle, Last) ROBERT CLARK | | | | 18. Mother's Name (First, Middle, Maiden Surname) ALPHA PINKSTON | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ROBERT DOAK/SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1115 OYSTER COVE DR., GRASONVILLE, MD 21638 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) STEVENSVILLE CEMETERY | | 20c. Date 04/29/2004 | | 20d. Location - City or Town, State STEVENSVILLE, MD | | |
| 21. Signature of Funeral Service Licensee <i>Chad H. [Signature]</i> | | 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Paranoid Schizophrenia Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. Approximate Interval Between Onset and Death many yrs many yrs many yrs | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ALC | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | |
| 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Jan. [Signature]</i> MD | | 29c. License number D 40519 | | 29d. Date signed (Month, Day, Year) 4-28-04 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRZA M. NUSAIRBE, 1667, Crofton Medical Group, Crofton, MD 21114 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 29 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

CHH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15226

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lorraine A. Pink Evans

2. Date of Death

April 24 2004

3. Time of Death

1855 M

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

220-46-4797

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 2, 1917

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8 Chelsea Drive

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Clarence E. Pink

18. Mother's Name (First, Middle, Maiden Surname)

Julia Nuding

19a. Informant's Name/Relationship (Type, Print)

Edward N. Evans, II/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1317 Regatta Dr., Wilmington, NC 28405

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Old Trinity Cemetery

Date

4/28/2004

20c. Location - City or Town, State

Church Creek, MD

21. Signature of Funeral Service Licensee

Curran-Bromwell Funeral Home, P.A.

22. Name and Address of Facility

308 High St., Cambridge, MD 21613

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMOCOCCAL PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMOCOCCAL SEPSIS

Due to (or as a consequence of):

5 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

M 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. Friedman

29c. License number

D26388

29d. Date signed (Month, Day, Year)

April 24, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael J. Friedman MD 303 Collins Harlock MD 21643

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Bryan B. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15227

1- For
State
Registrar

| | | | | | | | | |
|---|---|--|---|--------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dorothy Poist Farmer | | | | 2. Date of Death Month Day Year April 27, 2004 | | 3. Time of Death 6:30 p ^M | |
| | 4a. Facility Name (If not institution, give street and number) Residence: 1568 Hopewell Road | | | | 4b. City, Town, or Location of Death Port Deposit | | 4c. County of Death Cecil | |
| Funeral Director | 5. Social Security Number 220-22-6950 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 5, 1927 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent 10a. State Maryland | | | | 10b. County Cecil | | 10c. City, Town or Location Port Deposit | |
| To Be Completed by Funeral Director | 10e. Street and Number 1568 Hopewell Road | | | | 10f. Zip Code 21904 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Twelve Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Administrative Assistant | | 16b. Kind of Business/Industry Aberdeen Proving Ground Aberdeen, Maryland | | | |
| | 17. Father's Name (First, Middle, Last) George Washington Poist | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marian H. Keilholtz | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Delmar Farmer (husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1568 Hopewell Road, Port Deposit, Maryland 21904 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hopewell Cemetery | | Date 04/30/04 | | 20c. Location - City or Town, State Port Deposit, Maryland | |
| | 21. Signature of Funeral Service Licensee <i>Shoreen M. Patterson, Sr.</i> | | | | 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC CARCINOMA OF LUNG b. CARCINOMA LUNG c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | | | | |
| | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | | | | |
| 23d. Date of delivery Month Day Year | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC PULMONARY FIBROSIS CHRONIC LYMPHOCYTIC LEUKEMIA | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>Shoreen M. Patterson, M.D.</i> | | | | 29c. License number D-15994 | | 29d. Date signed (Month, Day, Year) 4/29/04 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEICIA S. GALVEZ M.D. 625 S. UNION AVE. HAVER PEARCE MD. 21078 | | | | | | | |
| | State Registrar | 31. Date filed (Month, Day, Year) APR 29 2004 | | | | 32. Registrar's Signature <i>Shoreen M. Patterson</i> | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Unpend Item #23a, 27, 28a-1 per me 6831 5/13/04 tas 2004 15228

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death Reg. No.

| | | | | | | | |
|---|--|--|--|--|--|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Patrick James Fish | | | 2. Date of Death Month Day Year APRIL 30, 2004 | | 3. Time of Death 2:18P. M | |
| | 4a. Facility Name (If not institution, give street and number) HARFORD MEMORIAL HOSPITAL | | | 4b. City, Town, or Location of Death HAVRE de GRACE | | 4c. County of Death HARFORD | |
| Funeral Director | 5. Social Security Number 076-60-4932 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 27 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 9, 1977 |
| | 9. Birthplace (State or Foreign Country) New York | | 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Perryville |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 27 White Oak Drive | | 10f. Zip Code 21903 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Twelve Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Concrete Finisher | | 16b. Kind of Business/Industry J & M Concrete Perryville, Maryland | | |
| | 17. Father's Name (First, Middle, Last) David Martin Fish | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Evans | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Sheri M. Fish (wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 White Oak Drive, Perryville, Maryland 21903 | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Co., Inc. | | 20c. Location - City or Town, State West Chester, Pennsylvania | | 20d. Date 05/05/04 |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee <i>Thomas H. Patterson, Sr.</i> | | 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Heroin Intoxication</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | | |
| To Be Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) Found 4/30/2004 | | 28b. Time of Injury Found 1:00 P M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 28d. Describe how injury occurred Unknown | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 27 White Oak Drive Perryville, Md | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>A. Rubio, MD</i> | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) MAY 1, 2004 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) MAY 4 2004 | | 32. Registrar's Signature <i>Kevin B. Smith</i> | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15229

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George John Faina

2. Date of Death

April 23, 2004

3. Time of Death

11:00 P M

4a. Facility Name (If not institution, give street and number)

Mariner Health Care- Silver Spring

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-01-1871

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 1, 1909

9. Birthplace (State or Foreign Country)

Louisiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2722 Kirkwood Place, #103

10f. Zip Code

20782

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pressman

16b. Kind of Business/Industry

Printing Press

17. Father's Name (First, Middle, Last)

Peter L. Faina

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Ferrarra

19a. Informant's Name/Relationship (Type, Print)

Toni Rizzo Miskell/ Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1820 Paddy Court, Huntingtown, MD 20639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date
April 28, 200420c. Location - City or Town, State
Silver Spring, MD

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dysphagia, Atrial Fibrillation

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Yeheyis Negussie

29c. License number

D45471

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yeheyis Negussie M.D. 1111 Spring Street, #214, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Benjamin S. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, this Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15230

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Katherine M. Funk

2. Date of Death

05 01 04

3. Time of Death

2239 M

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegheny

Funeral
Director

5. Social Security Number

214-30-9740

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Oct. 24, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegheny

10c. City, Town or Location

Cresaptown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14916 Grant St.

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Anthony L. Logsdon

18. Mother's Name (First, Middle, Maiden Surname)

Rosella Kuhlman

19a. Informant's Name/Relationship (Type, Print)

Eugene R. Funk - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14916 Grant St., Cresaptown, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SS Peter & Paul

Date

May 5, 2004

20c. Location - City or Town, State

Cumberland MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hafer Funeral Service PA

1302 National Hwy., LaVale, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC Dysrhythmia

Due to (or as a consequence of):

b. Complete Heart block

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 HOURS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Large Hematoma on (R) Abdominal Wall and Right groin

STATUS INFERIOR VENA CAVAL Filter

Left Deep Vein Thrombosis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

S. Changin

29c. License number

D 256 38

29d. Date signed (Month, Day, Year)

May 2 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATURNIA CHANG MD 10701 New Georgia Creek S.W. Front Royal Maryland 21532

31. Date filed (Month, Day Year)

MAY 12 2004

32. Registrar's Signature

John S. Spivey

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

7

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15231

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Betty Bailey Feeney

2. Date of Death

Month Day Year
April 21, 2004

3. Time of Death

1:23pm M

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

579-07-5708

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 14, 1915

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

230 Beckwith Street

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Lumber Company

17. Father's Name (First, Middle, Last)

Earl Russell Bailey

18. Mother's Name (First, Middle, Maiden Surname)

Agatha Hagerty

19a. Informant's Name/Relationship (Type, Print)

John Feeney (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

230 Beckwith Street, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

4/26/04

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home
10 East Deer Park Drive
Gaithersburg, MD 20877

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Years

Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Dooley, MD 9901 Medical Center Drive, Rockville, MD 20850

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15232

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Maria Flores

2. Date of Death

Month Day Year
April 27, 2004

3. Time of Death

10:20a M

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

228-57-2554

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

2/02/1929

El Salvador

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

16101 Crabbs Branch Way

10f. Zip Code

20855

10g. Citizen of What Country?

El Salvador

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No
Specify: El Salvador

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Justo Flores

18. Mother's Name (First, Middle, Maiden Surname)

Andrea Flores Roque

19a. Informant's Name/Relationship (Type, Print)

David Flores/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4940 Little Falls Arlington, Virginia 22207

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven

Date

4/29/04

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Philip D. Rinaldi

22. Name and Address of Facility

PHILIP D. RINALDI FUNERAL SERVICE, P.A.
9241 Columbia Blvd. Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cancer

Due to (or as a consequence of):

b. Malignant neoplasm of lung

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Kaplan MD

29c. License number

D35635

29d. Date signed (Month, Day, Year)

April 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan MD 6001 Muncaster Mill Rockville, Md 20855

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15233

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

AnneLee Broadus Forrester

2. Date of Death

Month Day Year
April 22, 2004

3. Time of Death

11:40 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Maplewood Park Place

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

497-28-2812

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
6/17/11

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9707 Old Georgetown Road

10f. Zip Code

20814

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Investor

16b. Kind of Business/Industry

Capital Markets

17. Father's Name (First, Middle, Last)

Jesse Norris Broadus

18. Mother's Name (First, Middle, Maiden Surname)

Era Bridgeford

19a. Informant's Name/Relationship (Type, Print)

Anne F. Crawford-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 Sutton Place S New York, NY 10022

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Forrest Hill Cemetery

Date

5/17/04

20c. Location - City or Town, State

Kansas City, MO

21. Signature of Funeral Service Licensee

M. L. X...

22. Name and Address of Facility

Joseph Gawler's Sons Inc.

5130 Wisconsin Ave. NW Washington, DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. STROKE

Due to (or as a consequence of):

4 MONTHS

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. Kaufman

29c. License number

D26259

29d. Date signed (Month, Day, Year)

4/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVA A KAUFMAN, MD 8218 WISCONSIN AVE

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

A. Kaufman

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15234

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) **ELSA FRIEDMAN** 2. Date of Death Month Day Year **APRIL 24, 2004** 3. Time of Death **11:40 P.M.**

4a. Facility Name (If not institution, give street and number) **11517 Karen Drive** 4b. City, Town, or Location of Death **Potomac** 4c. County of Death **Montgomery**

Funeral Director

5. Social Security Number **218-42-5232** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **93** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **June 5, 1910** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent 10a. State **Florida** 10b. County **Broward** 10c. City, Town or Location **Hallandale** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **3161 S. Ocean Drive, # 1508** 10f. Zip Code **33009** 10g. Citizen of What Country? **U. S. A.**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **12 Years** College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 16b. Kind of Business/Industry **Own Home**

17. Father's Name (First, Middle, Last) **Philip Fine** 18. Mother's Name (First, Middle, Maiden Surname) **Ida Bisker**

19a. Informant's Name/Relationship (Type, Print) **Philip G. Berman - Son** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **11517 Karen Drive, Potomac, Maryland 20854**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Shaarei Tfiloh Cong.** Date **4/25/2004** 20c. Location - City or Town, State **Baltimore, Maryland**

21. Signature of Funeral Service Licensee **Donald C. Stettin** 22. Name and Address of Facility **Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Colon Cancer - Metastatic** a. Due to (or as a consequence of): **Bone - Metastasis** b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximately Interval Between Onset and Death **10 Yrs.**

23b. Was decedent pregnant in the past 12 months? ☐ Yes ☒ No ☐ Unknown 23c. If yes, outcome of pregnancy ☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy ☐ Pregnant at time of death ☐ Other (specify) ☐ Unknown 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA 26. Place of Death (Check only one) Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify) **Hospice Care at Son's Residence**

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **B. M.D.** 29c. License number **D0059244** 29d. Date signed (Month, Day, Year) **4/25/2004**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Giselle Mery, M. D. 5622 Shields Drive, Bethesda, Maryland 20817**

31. Date filed (Month, Day, Year) **APR 27 2004** 32. Registrar's Signature **Sparks**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15235

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Linda Helen Friend

2. Date of Death

Month Day Year
April 28, 2004

3. Time of Death

8:02A. M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4711 Lincoln Avenue

4b. City, Town, or Location of Death

Beltsville

4c. County of Death

Prince George's

5. Social Security Number

579-58-4584

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 12, 1946

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4711 Lincoln Avenue

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (9-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Executive Housekeeper

16b. Kind of Business/Industry

Holiday Inn

17. Father's Name (First, Middle, Last)

Irving Lee Cumberland

18. Mother's Name (First, Middle, Maiden Sumame)

Juanita Schlagle

19a. Informant's Name/Relationship (Type, Print)

Arthur A. Friend -Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4711 Lincoln Avenue Beltsville, Maryland 20705

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery 5/3/2004

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt Funeral Home, P.A.

22. Name and Address of Facility

4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Non small cell lung cancer

Approximate Interval Between Onset and Death

15 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

- a. Due to (or as a consequence of):
- b. Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death
☐ Pregnant at time of death ☐ Ectopic pregnancy
☐ Unknown ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

23e. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas A. Bensinger, M.D.

29c. License number

D08754

29d. Date signed (Month, Day, Year)

April 28, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas A. Bensinger, M.D. 7525 Greenway Center Dr., #205 Greenbelt, Maryland 20770

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

Geneva B Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, this Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15236

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rene Mauricio Fuentes

2. Date of Death

April 23, 2004

3. Time of Death

556 P M

4a. Facility Name (If not institution, give street and number)

651 Saybrooke Oaks Blvd. Rear

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

212-98-4397

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 26, 1959

9. Birthplace (State or Foreign Country)

El Salvador

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7804 Guildberry Court, Apt. 201

10f. Zip Code

20879

10g. Citizen of What Country?

El Salvador

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify: Salvadoran14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Construction Worker

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Gregorio Fuentes

18. Mother's Name (First, Middle, Maiden Surname)

Maria Catalina Navas

19a. Informant's Name/Relationship (Type, Print)

Jorge A. Rivas/ Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11609 Queen Nicole Terrace, Germantown, MD 20876

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Gate of Heaven
Cemetery

Date

April 29,
2004

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. TWO STAB WOUNDS, MULTIPLE CUTTING WOUNDS, AND BLUNT FORCE INJURY

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?24b. Were autopsy findings available
prior to completion of cause of
death?1 ☒ Yes 2 ☐ No1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

At Scene

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

FOUN 4/23/04

28b. Time of Injury

540 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT WAS STABBED, CUT AND ASSAULTED

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

FOUND IN WOODS

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

651 SAYBROOKE OAKS BLVD, GAITHERSBURG, MD

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 24, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY G. RIPLEY, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 29 2004

32. Registrar's Signature

B Spauld

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15237

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) BEATRICE W. FUHRMAN | | 2. Date of Death Month Day Year APRIL 24, 2004 | | 3. Time of Death 3:00 A M | |
| 4a. Facility Name (If not institution, give street and number) HOMEWOOD AT CRUMLAND FARM NURSING HOME | | 4b. City, Town, or Location of Death FREDERICK | | 4c. County of Death FREDERICK | |
| 5. Social Security Number 577-12-4619 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | 8. Date of Birth (Month, Day, Year) 11/01/1916 | 9. Birthplace (State or Foreign Country) NEW YORK | |
| Usual Residence of Decedent | | | | | |
| 10a. State MARYLAND | 10b. County FREDERICK | 10c. City, Town or Location THURMONT | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 16018 KELBAUGH ROAD | | 10f. Zip Code 21788 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CIVIL SERVICE WORKER | |
| 16b. Kind of Business/Industry STATE DEPARTMENT | | 17. Father's Name (First, Middle, Last) BENJAMIN WARSAW | | 18. Mother's Name (First, Middle, Maiden Surname) SELMA COHEN | |
| 19a. Informant's Name/Relationship (Type, Print) FREDERICK FUHRMAN/SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16018 KELBAUGH RD., THURMONT, MARYLAND 21788 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. LEBANON CEMETERY | | 20c. Location - City or Town, State ADELPHI, MARYLAND | |
| 21. Signature of Funeral Service Licensee <i>Amanda Ludewig</i> | | 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | |
| Approximate Interval Between Onset and Death YEARS | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LEFT NON-HEALING FEMUR FRACTURE | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 09/17/2003 | | 28b. Time of Injury 12:00 P M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred FELL AT RESIDENCE | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) RESIDENCE | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 16018 KELBAUGH RD., THURMONT | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Andrew Zarick</i> | | 29c. License number D35164 | | 29d. Date signed (Month, Day, Year) APRIL 24, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW ZARICK, M.D., 15 WEST SEVENTH ST., FREDERICK, MD 21701 | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature <i>Benjamin B. Sparks</i> | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No.

2004 15238

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCIS FURNARY

2. Date of Death

Month Day Year
April 24, 2004

3. Time of Death

10:45 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

577-28-5135

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 24, 1923

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

517 Blick Dr.

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank Heley

18. Mother's Name (First, Middle, Maiden Surname)

Anna Ward

19a. Informant's Name/Relationship (Type, Print)

Benjamin G. Furnary- Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

517 Blick Dr. Silver Spring, MD 20904

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cem.

Date

04/27/2004 Silver Spring, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Derek E. Wil

22. Name and Address of Facility

Hines-Rinaldi Funeral Home
11800 New Hampshire Ave. Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INTRACRANIAL BLEED

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
4 DAYS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

1 Inpatient

☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Physician

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Signature of Certifier

29c. License number

D25009

29d. Date signed (Month, Day, Year)

April 24, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pamela Mulshine, M.D. 10801 Lockwood Dr. #205 Silver Spring, MD 20901

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

Signature of Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15239

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID BENJAMIN FREY, SR.

2. Date of Death
Month Day Year
APRIL 27 20043. Time of Death
1:30PM MFuneral
Director

4a. Facility Name (If not institution, give street and number)

9409 MARTINGHAM CIRCLE

4b. City, Town, or Location of Death

ST. MICHAELS

4c. County of Death

TALBOT

5. Social Security Number

214-12-4797

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

AUG 22 1920

9. Birthplace (State or Foreign
Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

ST. MICHAELS

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number

9409 MARTINGHAM CIRCLE

10f. Zip Code

21663

10g. Citizen of What Country?

USA

11. Marital Status
1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: WHITE15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ENGINEER

16b. Kind of Business/Industry

COMMUNICATIONS

17. Father's Name (First, Middle, Last)

EDWARD L. FREY

18. Mother's Name (First, Middle, Maiden Surname)

RITA TIEMEYER

19a. Informant's Name/Relationship (Type, Print)

JOAN A. FREY/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO BOX 1280 ST. MICHAELS, MD 21663

20a. Method of Disposition
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHESAPEAKE CREMATION CTR. 4-28-2004 STEVENSVILLE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M. H. Newnam III CFSP

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A.
200 S. HARRISON ST EASTON, MD 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Malignant Brain Tumor - Glioblastoma

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
2 mos

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (Specify)23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Russell A. Schilling

29c. License number

M42587

29d. Date signed (Month, Day, Year)

04/28/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Russell A Schilling DO 555 Cyanwood Dr Easton MD 21601

State
Registrar

31. Date filed (Month, Day, Year)

APR 29 2004

32. Registrar's Signature

Russell A. Schilling

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15240

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Raymond Gesell

2. Date of Death

Month April Day 26 Year 2004

3. Time of Death

6:02 PM

4a. Facility Name (If not institution, give street and number)

9 Monroe Street

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

220-18-2160

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Sept Day 3 Year 1925

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9 Monroe Street

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1946
194713. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Sewing Machine Mechanic

16b. Kind of Business/Industry

Westminster Knit Co

17. Father's Name (First, Middle, Last)

John Henry Gesell

18. Mother's Name (First, Middle, Maiden Surname)

Eva Blanche Autz

19a. Informant's Name/Relationship (Type, Print)

John W. Gesell/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

411 Red Tulip Court Taneytown, MD 21787

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Marys Cemetery

Date

4/30/2004

20c. Location - City or Town, State

Silver Run, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pritts Funeral Home and Chapel, P.A.

412 Washington Road Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Metastatic lymphoma
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

2 med

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29c. Signature and title of certifier

29d. License number

D37000

29e. Date signed (Month, Day, Year)

April 27th 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander Bogdanovskiy 2015 Semer Ave Westminster, MD 21157

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15241

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

PAUL LAVERNE GROFF

2. Date of Death

Month Day Year

MAY 4 2004

3. Time of Death

1:05 P M

4a. Facility Name (If not institution, give street and number)

CARROLL HOSPITAL CENTER

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

5. Social Security Number

186-22-6770

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 7, 1931

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CARROLL

10c. City, Town or Location

FINKSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2418 APPALOOSA WAY

10f. Zip Code

21048

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

ORDAINED MINISTER

16b. Kind of Business/Industry

MINISTRY

17. Father's Name (First, Middle, Last)

REINHART ROOKSTOOL GROFF

18. Mother's Name (First, Middle, Maiden Surname)

REBA HARRIET RUPERT

19a. Informant's Name/Relationship (Type, Print)

BARBARA J. GROFF/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2418 APPALOOSA WAY, FINKSBURG, MD 21048

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MEADOW BRANCH CEMETERY 5/8/2004

Date

20c. Location - City or Town, State

WESTMINSTER, MARYLAND

21. Signature of Funeral Service Licensee

Robert A. Myers

22. Name and Address of Facility

MYERS-DURBORAW FUNERAL HOME, P.A.

91 WILLIS STREET, WESTMINSTER, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PULMONARY FIBROSIS

Due to (or as a consequence of):

1 month

c. RADIATION/CHEMOTHERAPY

Due to (or as a consequence of):

3 months

d. HODGKIN'S DISEASE

Due to (or as a consequence of):

1 1/2 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AORTIC STENOSIS

EPILEPSY

HYPONATREMIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

ARTHUR L. RUDO ATTENDING PHYSICIAN

29c. License number

D21155

29d. Date signed (Month, Day, Year)

MAY 4, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARTHUR L. RUDO MD 904 WASHINGTON ROAD WESTMINSTER, MD 21157

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

Brian G. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15242

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EARL GEORGE

2. Date of Death

Month Day Year
APRIL 23, 2004

3. Time of Death

3:10 A^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

194-10-9537

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 26, 1915

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND MONTGOMERY

10b. County

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6105 MONTROSE ROAD #4130

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII
KOREAN13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ELECTRONICS REPAIR

16b. Kind of Business/Industry

CIVIL SERVICE

17. Father's Name (First, Middle, Last)

EDWARD

GEORGE

18. Mother's Name (First, Middle, Maiden Surname)

LILLIAN

BAYLOR

19a. Informant's Name/Relationship (Type, Print)

MIMI TORREANO/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10106 STERLING DR., ROCKVILLE, MD 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MT. COMFORT CREMATORY 04/27/2004 ALEXANDRIA, VIRGINIA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

acute myocardial infarction

b. Due to (or as a consequence of):

pneumonia

c. Due to (or as a consequence of):

Sequentially list conditions
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M Means Markwell

29c. License number

MD54722

29d. Date signed (Month, Day, Year)

4/23/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. M. MEANS-MARKWELL, M.D., 8600 OLD GEORGETOWN ROAD, BETHESDA, MD 20814

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Benita B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2+1

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15243

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) <u>Ada Greene</u> | | | | 2. Date of Death Month <u>April</u> Day <u>25</u> Year <u>2004</u> | | 3. Time of Death <u>12:33PM</u> | |
| 4a. Facility Name (If not institution, give street and number) <u>2400 Michigan Ave</u> | | | | 4b. City, Town, or Location of Death <u>Silver Spring</u> | | 4c. County of Death <u>Montgomery</u> | |
| 5. Social Security Number <u>216-50-9570</u> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>84</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>Oct. 25, 1919</u> | |
| 9. Birthplace (State or Foreign Country) <u>Virginia</u> | | Usual Residence of Decedent | | | | | |
| 10a. State <u>MD</u> | | 10b. County <u>Montgomery</u> | | 10c. City, Town or Location <u>Silver Spring</u> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number <u>2400 Michigan Ave</u> | | | | 10f. Zip Code <u>20910</u> | | 10g. Citizen of What Country? <u>U.S.A.</u> | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>Black</u> | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>2</u> College (1-4or 5+) <u>2</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Nurse</u> | | 16b. Kind of Business/Industry <u>Freedman's Hospital</u> | |
| 17. Father's Name (First, Middle, Last) <u>Oscar James</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Mary Harris</u> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Deloris Gassaway-Daughter</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1801 Smith Village Rd Silver Spring, MD 20904</u> | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Parklawn Memorial</u> | | 20c. Location - City or Town, State <u>Rockville, MD</u> | |
| 21. Signature of Funeral Service Licensee <u>[Signature]</u> | | | | 22. Name and Address of Facility <u>Snowden Funeral Home, P.A. 246 N Washington St Rockville, MD 20850</u> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | |
| a. <u>Sepsis</u> Due to (or as a consequence of): <u>7 days</u> | | | | | | | |
| b. <u>Pressure Ulcers</u> Due to (or as a consequence of): <u>14 days</u> | | | | | | | |
| c. <u>Alzheimer's Type Dementia</u> Due to (or as a consequence of): <u>5 yrs</u> | | | | | | | |
| d. | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | | | | | | |
| 23d. Date of delivery Month Day Year | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <u>[Signature]</u> | | | | 29c. License number <u>H0054337</u> | | 29d. Date signed (Month, Day, Year) <u>4/26/04</u> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Richard G. Stefanacci DO 3250 Starting Gate Ct Woodlawn</u> | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>APR 28 2004</u> | | | | 32. Registrar's Signature <u>[Signature]</u> | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15244

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PAYTON GRIFFIN

2. Date of Death

Month Day Year
APRIL 26 2004

3. Time of Death

8:45 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

578 24 0182

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
March 1 1923

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Damascus

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

10904 Middleboro Drive

10f. Zip Code

20872

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Albert Sydney Griffin

18. Mother's Name (First, Middle, Maiden Surname)

O'Keese Coggin

19a. Informant's Name/Relationship (Type, Print)

Steven M. Griffin / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10904 Middleboro Drive, Damascus, Md. 20872

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crem.

Date

4/28/04

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

Muriel H. Barber Funeral Home
P. O. Box 5038, Laytonsville, Md. 20882

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ASPIRATION PNEUMONIA

Approximate

Interval Between

Onset and Death

DAYS

Immediate Cause (Final

disease or condition

resulting in death)

a. Due to (or as a consequence of):
CEREBROVASCULAR ACCIDENT

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Posttraumatic pulmonary disease

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending2 ☐ Accident investigation3 ☐ Suicide 6 ☐ Could not be4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

Alan S. Chanales

29c. License number

29453

29d. Date signed (Month, Day, Year)

APRIL 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN S. CHANALES, M.D. 15225 SHADY GROVE RD., ROCKVILLE, MD. 20850

31. Date filed (Month, Day, Year)

APR 29 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12-1

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15245

1- For State Registrar

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Beatrice M. Gudridge

2. Date of Death

April 20, 2004

3. Time of Death

5:15 A.M.

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

127-07-7805

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Feb. 24, 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

514 Russell Avenue

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Journalist

16b. Kind of Business/Industry

Journalism

17. Father's Name (First, Middle, Last)

Christian Maul

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Usher

19a. Informant's Name/Relationship (Type, Print)

Kevin Gudridge/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1821 Harvard Avenue, # 203, Seattle, WA 98122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 4/22/2004

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c. CORONARY HEART DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Ectopic pregnancy
9 ☐ Unknown Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Merlyn Vemury MD

29c. License number

D35791

29d. Date signed (Month, Day, Year)

4/20/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MERLYN VEMURY, M.D.
9801 GEORGIA AVE, SILVER SPRING - MD 20902

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Benjamin S. Sparks

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15246

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dora A. Guevara

2. Date of Death
Month Day Year
April 22, 20043. Time of Death
4:50am M

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

220-15-0009

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year
Months Days Hours Min.8. Date of Birth
(Month, Day, Year)

Dec. 10, 1930

9. Birthplace (State or Foreign Country)

El Salvador

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number

7838 Yankee Harbor Drive

10f. Zip Code

20886

10g. Citizen of What Country?

El Salvador

11. Marital Status
1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify: El Salvadorian14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Doroteo Reyes

18. Mother's Name (First, Middle, Maiden Sumame)

Maria Eustaquia Guevara

19a. Informant's Name/Relationship (Type, Print)

(Daughter)

Anna Elizabeth Modenessi

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7838 Yankee Harbor Drive, Gaithersburg, MD 20886

20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery 4/26/04

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home
10 East Deer Park Drive
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Small Cell Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death
6 Months

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

29c. License number

D00041218

29d. Date signed (Month, Day, Year)

4/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Harrison 6001 Muncaster Mill Road, Rockville, MD 20855

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Unpend Item #23a&27 per me G831 5/13/04 tas

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15247

1- For State Registrar

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Dorothy Jean Goldstein

2. Date of Death

May 5, 2004

3. Time of Death

1032 P. M.

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

212-68-1777

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 9, 1955

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

14007 Westview Forest Drive

10f. Zip Code

20720

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Hair Salon

17. Father's Name (First, Middle, Last)

George

Salamy

18. Mother's Name (First, Middle, Maiden Surname)

Thelma

C.

Igal

19a. Informant's Name/Relationship (Type, Print)

Daniel Goldstein/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14007 Westview Forest Drive, Bowie, Maryland 20720

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Huntt Crematory

Date

5/7/2004

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Robert E. Evans Funeral Home

16000 Annapolis Road, Bowie, Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Coronary Artery Dissection With Thrombosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 6, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANETA RUBIO, MD

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)

MAY 07 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15248

1- For
State
Registrar

| | | | | | | | | |
|--|---|--|---|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANNA RAY HUNTER | | | | 2. Date of Death Month 5 Day 6 Year 04 | | 3. Time of Death 7:27 A^M | |
| | 4a. Facility Name (If not institution, give street and number) CAROL HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death WESTMINSTER | | 4c. County of Death CARROLL | |
| Funeral Director | 5. Social Security Number 220-46-4305 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 99 Yrs. | | 8. Date of Birth (Month, Day, Year) JULY 26, 1904 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County CARROLL | | 10c. City, Town or Location HAMPSTEAD | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 4016 BECKLEYSVILLE ROAD | | 10f. Zip Code 21074 | | 10g. Citizen of What Country? UNITED STATES | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry DOMESTIC | | | |
| | 17. Father's Name (First, Middle, Last) JOHN WESLEY REAVER, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname) ADDIE AGNES HAIFLEY | | | |
| | 19a. Informant's Name/Relationship (Type, Print) PEGGY MARTIN/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4016 BECKLEYSVILLE RD, HAMPSTEAD, MD 21074 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ST. JOHN LUTHERAN CEMETERY | | 20c. Location - City or Town, State WESTMINSTER, MD | | 20d. Date 5/10/04 | |
| | 21. Signature of Funeral Service Licensee <i>Justin R. [Signature]</i> | | | | 22. Name and Address of Facility MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, MD 21157 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 1 WEEK | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | |
| | 23d. Date of delivery Month Day Year | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION HYPOTHYROIDISM | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Justin R. [Signature] D.O.</i> | | 29c. License number H0058598 | | 29d. Date signed (Month, Day, Year) 5/6/04 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TRINA KAPOOR FRANKEL | | 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | 21157 | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

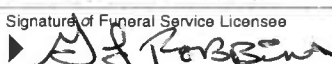
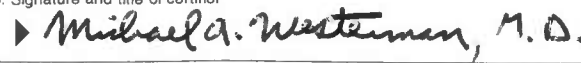

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15249

1- For State Registrar

| | | | | | | | | | | |
|--|---|---|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary Louise Hoffman | | | | 2. Date of Death Month Day Year April 24 2004 | | | | 3. Time of Death 8:45 P M | |
| | 4a. Facility Name (If not institution, give street and number) Suburban Hospital | | | | 4b. City, Town, or Location of Death Bethesda | | | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 404-05-1287 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 7, 1919 | | 9. Birthplace (State or Foreign Country) Kentucky | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 2900 North Leisure World Blvd., #210 | | | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant | | 16b. Kind of Business/Industry Retail | | | |
| | 17. Father's Name (First, Middle, Last) Hoyt C. Higgins | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lola M. Noland | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Hubert Lee Hoffman/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 North Leisure World Blvd., #210, Silver Spring Maryland 20906 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery | | Date May 17, 2004 | | 20c. Location - City or Town, State Arlington, Virginia | | | |
| | 21. Signature of Funeral Service Licensee  M01356 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | |
| Medical Certification; To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease Drug induced Lupus Erythematosus Acute Renal Failure | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier  Michael A. Westerman, M.D. | | | | 29c. License number D52451 | | 29d. Date signed (Month, Day, Year) April 25, 2004 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Westerman, M.D., 11125 Rockville Pike, #103, Rockville, Maryland 20852 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15250

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Adam Huless

2. Date of Death

Month Day Year
April 25, 2004

3. Time of Death

9:24 a.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

577-58-4912

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 31, 1910

9. Birthplace (State or Foreign Country)

Jersey City, NJ

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1820 Metzert Road, #35

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Employment Officer

16b. Kind of Business/Industry

U.S. Dept. of Agriculture
Federal Government

17. Father's Name (First, Middle, Last)

John Huless

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Hehner

19a. Informant's Name/Relationship (Type, Print)

Helen B. Huless/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1820 Metzert Road, #35, Adelphi, MD 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

April 29, 2004

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Annette Parker

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):
Chronic Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen M. Smith M.D.

29c. License number

45203

29d. Date signed (Month, Day, Year)

April 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen M. Smith M.D.

8401 Colesville Rd., Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15251

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Stanley Harvey

2. Date of Death

Month Day Year
04 27 2004

3. Time of Death

1435

4a. Facility Name (If not institution, give street and number)

Garrett County Memorial Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral
Director

5. Social Security Number

218 16 3686

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 7 1922

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Swanton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

122 Mt. Zion Rd.

10f. Zip Code

21561

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Coal Miner

16b. Kind of Business/Industry

Coal

17. Father's Name (First, Middle, Last)

Randolph Harvey

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Tichinel

19a. Informant's Name/Relationship (Type, Print)

Dale Harvey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

122 Mt. Zion Rd. Swanton, MD 21561

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Zion Cemetery

Date

Apr 30, 04

20c. Location - City or Town, State

Mt. Zion MD

21. Signature of Funeral Service Licensee

David A. Burdock

22. Name and Address of Facility

David A. Burdock FH

710 Church St. Kitzmiller, MD 21538

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Metastatic Esophageal Cancer
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

4 yrs.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage Emphysema.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. Robert Goralksi

29c. License number

D23979

29d. Date signed (Month, Day, Year)

4.27.04

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Robert Goralksi, 311 North Fourth Street, Oakland, MD 21550

State

Registrar

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 15252

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | |
|---|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CONSTANCE K. HURLEY | | 2. Date of Death Month Day Year APRIL 30 2004 | | 3. Time of Death 7:53 AM |
| | 4a. Facility Name (If not institution, give street and number) CORSICA HILLS NURSING HOME | | 4b. City, Town, or Location of Death CENTREVILLE | | 4c. County of Death QUEEN ANNE'S |
| Funeral Director | 5. Social Security Number 218-20-5775 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | 8. Date of Birth (Month, Day, Year) JAN. 22, 1926 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | Usual Residence of Decedent | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County QUEEN ANNE'S | 10c. City, Town or Location CENTREVILLE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 104 TILGHMAN TERRACE AVENUE | | 10f. Zip Code 21617 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -0- | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY | | 16b. Kind of Business/Industry REAL ESTATE | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) LOUIS O'DELL KELLEY | | 18. Mother's Name (First, Middle, Maiden Surname) MARIE ELIZABETH THOMAS | | |
| | 19a. Informant's Name/Relationship (Type, Print) DAVID A. KELLEY/ SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 922 THOMPSON CREEK ROAD, STEVENSVILLE, MD 21666 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERAN CEMETERY | | 20c. Location - City or Town, State HURLOCK, MARYLAND |
| | 21. Signature of Funeral Service Licensee <i>Thomas K. Helfenbein</i> | | 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Diabetic Nephropathy Due to (or as a consequence of): b. Diabetic Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 6m 5yr | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Dr. J. Sprague</i> | | 29c. License number 072036 | | 29d. Date signed (Month, Day, Year) 4/30/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY J. SPRAGUE 2108 Piedmont Drive Chester MD 21619 | | | | | |
| 31. Date filed (Month, Day, Year) MAY - 4 2004 | | 32. Registrar's Signature <i>Heaven to Sprague</i> | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15253

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOYCE ANN HANES

2. Date of Death

APRIL 22 2004

3. Time of Death

4:00 P M

4a. Facility Name (If not institution, give street and number)

117 JOHNSON DRIVE

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

215-62-2482

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 27, 1952

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

PA

10b. County

BUCKS

10c. City, Town or Location

LEVITTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

40 NEWBERRY LANE

10f. Zip Code

19054

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

OLIN CHARLES NEWELL

18. Mother's Name (First, Middle, Maiden Surname)

DORCAS LEE TAWES

19a. Informant's Name/Relationship (Type, Print)

JOHN M. HANES/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

40 NEWBERRY LANE, LEVITTOWN, PA 19054

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

OLD MARDELA CEMETERY

Date

4/26/2004

20c. Location - City or Town, State

MARDELA SPRINGS, MD

21. Signature of Funeral Service licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 3171
1212 OLD OCEAN CITY ROAD, SALISBURY, MD 2180223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *acute myocardial infarction*
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

14 yrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) *Sister's Residence*

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 20715

29d. Date signed (Month, Day, Year)

4/27/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph A. Grasso, MD 145 E. Carroll St., A-1 Salisbury, MD 21801

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036 eks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar AMEND#10 per INF5/3/04, BW, MCO
AMEND#19 per INF5/3/04, BW, MCO
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg. No. 2004 15254

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

| | | | | | |
|--|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last) Leonard Jasper | | 2. Date of Death Month Day Year 4-24-04 | | 3. Time of Death 6:00 A^M | |
| 4a. Facility Name (If not institution, give street and number) Potomac Manor Care | | 4b. City, Town, or Location of Death Potomac | | 4c. County of Death Montgomery | |
| 5. Social Security Number 094-24-7177 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | 8. Date of Birth (Month, Day, Year) 11-26-1927 | | 9. Birthplace (State or Foreign Country) NY |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County Montgomery | 10c. City, Town or Location Chesapeake Rockville | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 4615 N. Park Ave. | | 10f. Zip Code 20815 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Textile Consultant | | 16b. Kind of Business/Industry | | | |
| 17. Father's Name (First, Middle, Last) Ezekiel Jasper | | | 18. Mother's Name (First, Middle, Maiden Surname) Bertha Renner | | |
| 19a. Informant's Name/Relationship (Type, Print) Jane Jasper -wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4615 N. Park Ave. Rockville, MD 20815 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Mem. Park | | 20c. Location - City or Town, State 4-26-04 Olney, MD | |
| 21. Signature of Funeral Service Licensee Alan J. Daniels | | 22. Name and Address of Facility Hines-Rinaldi F. H. 11800 New Hampshire Ave. Silver Spring, MD 20904 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease 10 yrs Due to (or as a consequence of): Hypercholesterolemia 10 yrs Due to (or as a consequence of): Hypertension 10 yrs Due to (or as a consequence of): Diabetes Mellitus Type II 10 yrs | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28c. Describe how injury occurred | | 28d. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Anathan | | 29c. License number D0053615 | | 29d. Date signed (Month, Day, Year) April 26, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aruna S. Nathan, MD 11125 Rockville Pk, #208, Rockville, MD 20852 | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | 32. Registrar's Signature Aruna S. Nathan | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15255

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NORMAN BERAN JETTMAR

2. Date of Death

Month Day Year
April 26 2004

3. Time of Death

10:00P^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

924 Childs Point Road

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

577-42-2704

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 7, 1932

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

924 Childs Point Road

10f. Zip Code

21401

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

12/1952

to 12/1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Quality Control Officer

16b. Kind of Business/Industry

Color Matching Products
Manufacturing

17. Father's Name (First, Middle, Last)

Emil Jettmar

18. Mother's Name (First, Middle, Maiden Sumame)

Ella Beran

19a. Informant's Name/Relationship (Type, Print)

Eric B. Jettmar/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

201 Earle Branch Road, Centreville, Maryland 21617

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

05/01/2004

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Beattie

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 New Hampshire Avenue, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Gastric Cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Curtis Harris MD

29c. License number

D 53306

29d. Date signed (Month, Day, Year)

April 28, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Curtis Harris, M.D., 888 Bestgate Road, Suite #211, Annapolis, Maryland 21401

31. Date filed (Month, Day, Year)

APR 29 2004

32. Registrar's Signature

Kenna S Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15256

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dok Yun Jin

2. Date of Death

4-24-04

Month

Day

Year

3. Time of Death

4:30 A. M

4a. Facility Name (If not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

212-17-8669

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

5-18-51

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Korea

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13112 Fernedge Rd.

10f. Zip Code

20906

10g. Citizen of What Country?

Korea

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self-employed

18b. Kind of Business/Industry

Roofer

17. Father's Name (First, Middle, Last)

Chun Jin

18. Mother's Name (First, Middle, Maiden Surname)

Sun Yun

19a. Informant's Name/Relationship (Type, Print)

Tae Ja Jin - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13112 Fernedge Rd. Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cem.

Date

4-27-04

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Diane A. Cappelletti

22. Name and Address of Facility

Hines-Rinaldi F. H.

11800 New Hampshire Ave. Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent metastatic colon cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death
6+ months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Charles Harrison

29c. License number

00041218

29d. Date signed (Month, Day, Year)

4/24/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Harrison

6001 Muncaster Mill Rd. Rockville, MD 20852

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

Diane A. Cappelletti

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "Natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.




To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2004 15257

| | | | | | | | | |
|--|--|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Stefan Jodlowski | | | | 2. Date of Death Month April Day 22 Year 2004 | | 3. Time of Death 4:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) Western Maryland Health System, Sacred Heart Campus | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 268-38-9028 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Aug 13, 1911 | | 9. Birthplace (State or Foreign Country) Poland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Garrett | | 10c. City, Town or Location Grantsville | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 131 Killdeer Lane | | | | 10f. Zip Code 21536 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 5+ years | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professor of Sociology | | | 16b. Kind of Business/Industry University | |
| 17. Father's Name (First, Middle, Last) Piotr Jodlowski | | | | 18. Mother's Name (First, Middle, Maiden Surname) Julja Kopija | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Alina Jodlowski/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 Killdeer Lane, Grantsville, MD 21536 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Grantsville Cemetery, Apr 27, 2004 | | | 20c. Location - City or Town, State Grantsville, MD | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. septic shock Due to (or as a consequence of): b. septicemia Due to (or as a consequence of): c. urinary tract infection Due to (or as a consequence of): d. prostate cancer | | | | | | | | Approximate Interval Between Onset and Death 1 hour 3 weeks 4 weeks 13 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. atrial fibrillation, pheochromocytoma, atherosclerotic cerebrovascular disease | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D0025759 | | 29d. Date signed (Month, Day, Year) April 22, 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter K. Naumann, M.D., PO Box 247, 106 Cemetery Road, Accident MD 21520-0247 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15258

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Lee Kniphfer, Jr.

2. Date of Death

April

Day

30

Year

2004

3. Time of Death

2:13 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

9100 Block Atlantic Street

4b. City, Town, or Location of Death

Port Tobacco

4c. County of Death

Charles

5. Social Security Number

419-11-5795

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

24

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Feb. 29, 1980

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

LaPlata

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5100 Hawthorne Road

10f. Zip Code

20643

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Resort Park

17. Father's Name (First, Middle, Last)

William Lee Kniphfer, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Nan Marie Bufford

19a. Informant's Name/Relationship (Type, Print)

William Lee Kniphfer, Sr. Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5100 Hawthorne Rd., LaPlata, Md. 20646

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Funeral Service Alexandria, Va.

Date

May 3, 2004

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M00668

22. Name and Address of Facility

Williams Funeral Home, P.A. 20640
4270 Hawthorne Rd., Indian Head, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Drowning

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

Found 4-30-04

28b. Time of Injury

2:13 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUSPECT DROWNED, BOAT CAPSIZED

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

BODY OF W. KNIPHFER

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Found 9100 ATLANTIC - CHARLES

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 01, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARYANITA A. KOREN 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 03 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15259

| | | | | | | | | |
|--|---|---|--|--------------------------------------|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ralph E. Kendall | | | | 2. Date of Death Month Day Year April 29 2004 | | 3. Time of Death 09:50 AM | |
| | 4a. Facility Name (If not institution, give street and number) Williamsport Nursing Home | | | | 4b. City, Town, or Location of Death Williamsport | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 214-09-5424 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 25, 1910 | |
| | 9. Birthplace (State or Foreign Country) Chambersburg PA | | 10a. State MD | | 10b. County Washington | | 10c. City, Town or Location Williamsport | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 154 N. Artizan ST | | 10f. Zip Code 21795 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator | | 16b. Kind of Business/Industry Shoe Machinery | | | |
| | 17. Father's Name (First, Middle, Last) Charles D. Kendall | | | | 18. Mother's Name (First, Middle, Maiden Surname) Carla B. Miner | | | |
| | 19a. Informant's Name/Relationship (Type, Print) George W. Kendall son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10701 Oak Forrest DR Hagerstown, MD 21740 | | | |
| | 20a. Method of Disposition 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory, or other place) cumberland valley crematorium | | Date May 4 2004 | | 20c. Location - City or Town, State Waynesboro, PA | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 S Broad ST Waynesboro, PA 17268 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 week | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure Renal Failure Dementia due to Alzheimer's Disease | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 <input checked="" type="checkbox"/> Probably 4 Unknown | |
| | 25. Was case referred to medical examiner? 1 Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. | | | | | | |
| 29b. Signature and title of certifier Cynthia Kuttner - Sands, MD | | | | 29c. License number D47451 | | 29d. Date signed (Month, Day, Year) April 29, 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Cynthia Kuttner - Sands, MD - Williamsport Nursing Home 154 North Artizan Street Williamsport, Maryland | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15260

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Se

Kao

2. Date of Death

Month
April

Day

26, 2004

Year

3. Time of Death

11:30A.M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

14413 Gunstock Court

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

543-86-5266

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
May 22, 1911

9. Birthplace (State or Foreign Country)

Tou Hng-Taiwan

Usual Residence of Decedent

10a. State
Virginia

10b. County

Fairfax

10c. City, Town or Location

Vienna

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10326 Dunn Meadow Road

10f. Zip Code

22182

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Asian

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

retail

17. Father's Name (First, Middle, Last)

Lin Gung

18. Mother's Name (First, Middle, Maiden Surname)

Zyon Ng

19a. Informant's Name/Relationship (Type, Print)

Tsong-Liang Kao/ son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10326 Dunn Meadow Rd. Vienna, Virginia 22182

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

George Washington Cem. 5/1/2004

Date

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

Ken R. Thomas

22. Name and Address of Facility

Donald V. Forwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Stroke
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

8 hours

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, type 2
Senile Dementia
Hypertension

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an
autopsy
performed?
☐ Yes ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other Daughter's home

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify):28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kenneth Cheng-Nan Chen, M.D.

29c. License number

0101023813 VA

29d. Date signed (Month, Day, Year)

April 28, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Cheng-Nan Chen, M.D. 312 S. Washington St., #6B Alexandria, Virginia 22314

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15261

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Leonard Thomas Kardy, Jr.

2. Date of Death
Month Day Year

April 25, 2004

3. Time of Death
7:38A M

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral Director

5. Social Security Number

220-42-3203

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 14, 1945

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

19513 Transhire Road

10f. Zip Code

20886

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Hotel

17. Father's Name (First, Middle, Last)

Leonard Thomas Kardy, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Kathryn Neel

19a. Informant's Name/Relationship (Type, Print)

Linda J. Kardy/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19513 Transhire Road, Montgomery Village, MD 20886

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

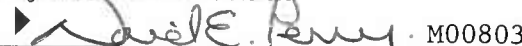
Date

April 28, 2004

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

 M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiomyopathy

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

54619

29d. Date signed (Month, Day, Year)

April 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Winters, M.D. 141 Thomas Johnson Drive, #200, Frederick, Maryland 21702

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature



State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15262

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leland M. Kane

2. Date of Death
Month Day Year
April 25, 20043. Time of Death
5:49 A. M.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

578-38-1830

6. Sex
1 ☐ M 2 ☐ F

X

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth (Month, Day, Year)

July 5, 1915

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

X ☐ Yes 2 ☐ No

10e. Street and Number

5225 Pooks Hill Road, # 413 North

10f. Zip Code

20814

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW 2

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Merchant

16b. Kind of Business/Industry

Jewelry

17. Father's Name (First, Middle, Last)

Samuel Cohn

18. Mother's Name (First, Middle, Maiden Surname)

Bertha (Unascertainable)

19a. Informant's Name/Relationship (Type, Print)

Marcia T. Kane - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5225 Pooks Hill Road, # 413N., Bethesda, Md. 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Mem. Gardens

Date

4/28/2004

20c. Location - City or Town, State

Olney, Maryland

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

Danzansky-Goldberg Memorial Chapels, Inc.
170 Rockville Pike, Rockville, Maryland 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Approximate Interval Between Onset and Death

2 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Septicemia

2 hours

Due to (or as a consequence of):

c. Interstitial Pulmonary Fibrosis

7 weeks

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease, Diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lee R. Pennington, MD

29c. License number

021115

29d. Date signed (Month, Day, Year)

4/25/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee R. Pennington, MD; 10215 Fernwood Road, Bethesda, MD 20817

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

James S. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15263

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Herman S. Kessler

2. Date of Death
Month Day Year
April 21, 2004

3. Time of Death
8:44 P.M.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral Director

5. Social Security Number

579-28-3336

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 15, 1928

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

8619 Bunnell Drive

10f. Zip Code

20854

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Navy
If Yes, Give Year or Dates 1952-1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Certified Public Accountant

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

Morris Kessler

18. Mother's Name (First, Middle, Maiden Surname)

Gussie Page

19a. Informant's Name/Relationship (Type, Print)

Doris B. Kessler - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8619 Bunnell Drive, Potomac, Maryland 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Comfort

Date

4/23/2004

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, Maryland 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Approximate Interval Between Onset and Death

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arrhythmia

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bradycardia s/p Pacemaker

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Emergency Physician

29c. License number

D54776

29d. Date signed (Month, Day, Year)

4/21/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barton W. Leonard, Suburban Hospital, Bethesda, MD

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Benjamin S. Sparks

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

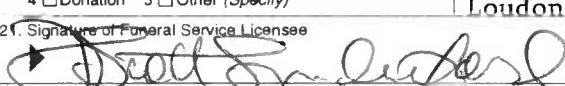
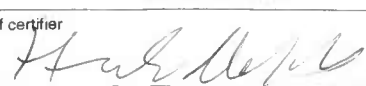

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15264

1- For
State
Registrar

| | | | | | | | | |
|---|--|---|---|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Thomas Kinkel | | | | 2. Date of Death Month April Day 26 Year 2004 | | 3. Time of Death 4:15 P M | |
| | 4a. Facility Name (If not institution, give street and number) 2209 Gaywoods Court | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 131-20-4166 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 28, 1922 | | 9. Birthplace (State or Foreign Country) New York |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 2209 Gaywoods Court | | | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Journalist | | 16b. Kind of Business/Industry Television | | | |
| | 17. Father's Name (First, Middle, Last) John Adam Kinkel | | | | 18. Mother's Name (First, Middle, Maiden Surname) Katherine Gertrude O'Brien | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Brien Kinkel - son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2209 Gaywoods Court, Silver Spring, MD 20906 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Crematory | | Date 4-28-2004 | | 20c. Location - City or Town, State Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death |
| | IF FEMALE 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death Check one Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D0056428 | | 29d. Date signed (Month, Day, Year) April 28, 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Humera Malik, M.D. 10810 Connecticut Ave., Kensington, MD 20895 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 29 2004 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Kristian G. Koncke
04-2819
AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

1- For State Registrar

Unpaid Item #23a, 27, 28a-1 per the C&S 5/25/04 tax

Certificate of Death

Reg. No.

2004 15265

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kristian George Koncke

2. Date of Death
Month Day Year
April 25, 2004

3. Time of Death
7:30 A^M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Assateague Island National Seashore

4b. City, Town, or Location of Death

Assateague Island

4c. County of Death

Worcester

5. Social Security Number

213-35-5114

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

25 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)

July 16, 1978

9. Birthplace (State or Foreign Country)

Uruguay

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Damascus

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number

10202 Crosscut Way

10f. Zip Code

20872

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Uruguayan

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Art Director

16b. Kind of Business/Industry

Web Design

17. Father's Name (First, Middle, Last)

Jorge Allan Koncke

18. Mother's Name (First, Middle, Maiden Surname)

Estella E. Fernandez

19a. Informant's Name/Relationship (Type, Print)

Katarzyna Anna Koncke/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10202 Crosscut Way, Damascus, MD 20872

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

April 27,
2004

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Richard Z. Bello

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

Hallucinogenic Tryptamine Intoxication

Approximate
Interval Between
Onset and Death

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an
autopsy
performed?
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☒ Yes 2 ☐ No

25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) At scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☒ Could not be
4 ☐ Homicide determined

28a. Date of Injury
(Month, Day, Year)

Found
4-25-04

28b. Time of
Injury

Found
6:30 a^M

28c. Injury at
Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Unknown

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

Found on island

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

Assateague Island

29a. Certifier
(Check only
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. McKing

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE MCKING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

James S. Sparks

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

David P. Kuntz
04-2852

AKG

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
2004 15266
Reg. No.

| | | | | | |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) David P. Kuntz | | 2. Date of Death Month Day Year April 26, 2004 | | 3. Time of Death 1:34 P M | |
| 4a. Facility Name (If not institution, give street and number) 11200 Evans Trail #202 | | 4b. City, Town, or Location of Death Beltsville | | 4c. County of Death Prince George's | |
| 5. Social Security Number 191-54-5117 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 32 Yrs. | 8. Date of Birth (Month, Day, Year) Oct. 9, 1971 | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Prince George's | 10c. City, Town or Location Beltsville | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 11200 Evans Trail, Apr.#202 | | 10f. Zip Code 20705 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chef | | 16b. Kind of Business/Industry Food Service | | | |
| 17. Father's Name (First, Middle, Last) Paul L. Kuntz | | | 18. Mother's Name (First, Middle, Maiden Surname) Shirley A. Leibensperger | | |
| 19a. Informant's Name/Relationship (Type, Print) Paul L. Kuntz-Father | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2380 Lower Smith Gap Rd. Kunkletown, PA 18058 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Location - City or Town, State 4/29/2004 Alexandria, Virginia | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Fatty Liver Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Fatty Liver b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) April 27, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUIZIO, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) APR 30 2004 | | 32. Registrar's Signature | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15267

1- For State Registrar

| | | | | | | | |
|---|--|---|--|--|---|--|---|
| Physician / Medical Examiner | 1. Decedent's Name (First, Middle, Last) Cuba Kane | | | 2. Date of Death Month April Day 23 Year 2004 | | 3. Time of Death 6:55 PM | |
| | 4a. Facility Name (If not institution, give street and number) 433-Willis Street | | | 4b. City, Town, or Location of Death Cambridge | | 4c. County of Death Dorchester | |
| Funeral Director | 5. Social Security Number 217-74-1979 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 42 Yrs. | 8. Date of Birth (Month, Day, Year) July 12, 1961 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | |
| 10a. State MD | | 10b. County Dorchester | | 10c. City, Town or Location Cambridge | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 433-Willis Street | | | 10f. Zip Code 21613 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly Line Worker | | 16b. Kind of Business/Industry Manufacturing | | |
| 17. Father's Name (First, Middle, Last) John L. Kane | | | | 18. Mother's Name (First, Middle, Maiden Surname) Clementine Chester | | | |
| 19a. Informant's Name/Relationship (Type, Print) Necole Kane | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Sunmar Court Apt. 2-C Baltimore, MD 21207 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Malone Cemetery | | Date 5/01/04 | | 20c. Location - City or Town, State Madison, Maryland | |
| 21. Signature of Funeral Service Licensee Janelle C. Henry | | | | 22. Name and Address of Facility Henry Funeral Home, P.A. 510 Washington St. Cambridge MD 21613 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Breast cancer with bone metastases | | | | | | | |
| 23b. Enter the immediate cause (Final disease or condition resulting in death). List only one cause on each line. Due to (or as a consequence of): | | | | | | | |
| 23c. Enter the underlying cause (Disease or injury that initiated events resulting in death). List only one cause on each line. Due to (or as a consequence of): | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 26a. Date of Injury (Month, Day Year) | | 26b. Time of Injury M | | 26c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 26a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 26b. Describe how injury occurred | | 26c. Location (Street and Number or Rural Route Number, City or Town, State) | | 26d. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Eugene Newmiller DO | | | | 29c. License number H51793 | | 29d. Date signed (Month, Day, Year) 4/26/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene Newmiller DO 503 Byrn St Cambridge MD 21613 | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | | | 32. Registrar's Signature Don H. Spivey | | | |

Baltimore, Maryland 21215-0036
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

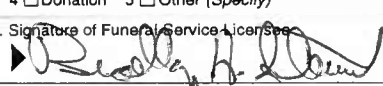
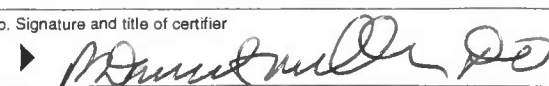

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15268

1- For State Registrar

| | | | | | | | | |
|---|---|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Helen Charlene KNOX | | | | 2. Date of Death Month Day Year April 24, 2004 | | 3. Time of Death 4:15 P M | |
| | 4a. Facility Name (If not institution, give street and number) Garrett County Memorial Hospital | | | | 4b. City, Town, or Location of Death Oakland | | 4c. County of Death Garrett | |
| Funeral Director | 5. Social Security Number 212-60-0591 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) Mar. 26, 1932 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Garrett | | 10c. City, Town or Location Oakland | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 215 N. 12th St. | | 10f. Zip Code 21550 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Home | | |
| 17. Father's Name (First, Middle, Last) LeMoyne Paul King | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nellie Agnes Steyer | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Peggy J. Knox/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 N. 12th St., Oakland, Md. 21550 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrett Co. Mem. Gdns | | 20c. Location - City or Town, State Oakland, Maryland | | 20d. Date 4/27/04 | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| Approximate Interval Between Onset and Death Weeks | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | | | |
| 23d. Date of delivery Month Day Year | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number H26154 | | 29d. Date signed (Month, Day, Year) 4/25/2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Daniel Miller D.O. 69 Wolf Acres Drive, Oakland, Md. 21550 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15269

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence Collins Lewis

2. Date of Death

Month Day Year
April 28 2004

3. Time of Death

1432 M

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

218 32 1049

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
September 26, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

444 Doris Circle

10f. Zip Code

21001

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Forklift Operator

16b. Kind of Business/Industry

Transport and Storage

17. Father's Name (First, Middle, Last)

James L. Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Ogretta McCrary

19a. Informant's Name/Relationship (Type, Print)

Gloria J. Starling/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 58, Charlestown, Maryland, 21914

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Charlestown Cemetery

Date

May 1, 2004 Charlestown, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, Maryland 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Metastatic Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D0055722

29d. Date signed (Month, Day, Year)

04/28/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Seong Chin 319 South Union Avenue, Havre de Grace, Maryland

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, 70

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Maxine Leaman

4/24/04 - 1157 AM.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15270

1- For
State
Registrar

| | | | | | | | | | | | |
|--|--|-------------------------------|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MAXINE E. LEAMAN | | | | 2. Date of Death Month Day Year APRIL 24, 2004 | | | | 3. Time of Death 11:57A M | | |
| | 4a. Facility Name (If not institution, give street and number) LONG VIEW NURSING HOME | | | | 4b. City, Town, or Location of Death MANCHESTER | | | | 4c. County of Death CARROLL | | |
| Funeral Director | 5. Social Security Number 577-05-7081 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) 7/3/1915 | | 9. Birthplace (State or Foreign Country) VIRGINIA | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD. | | 10b. County CARROLL | | 10c. City, Town or Location NEW WINDSOR | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 2823 CARLISLE DR. | | | | 10f. Zip Code 21776 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE | | | | 16b. Kind of Business/Industry HOME MAKER | | | |
| 17. Father's Name (First, Middle, Last) JOHNSON SNYDER EATON | | | | | 18. Mother's Name (First, Middle, Maiden Surname) MAUDE EMMALINE BELT | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) DIANA L. STULL -DAUGHTER | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 STONER AVE., WESTMINSTER, MD. 21157 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) FORT LINCOLN CEM. | | | Date 4/28/04 | | 20c. Location - City or Town, State BRENTWOOD, MD. | | | |
| 21. Signature of Funeral Service Licensee | | | | | 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Act 2 leukemia a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death year | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | | 23d. Date of delivery Month Day Year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | 29c. License number MD0336712 P33165 | | 29d. Date signed (Month, Day, Year) 4/27/04 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Parker 2111 Hanover Pk. Hampstead MD 21074 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature | | | | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15271

1- For
State
Registrar

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) KATHERINE P. LASHMIT | | | | 2. Date of Death Month Day Year April 24 2004 | | 3. Time of Death 4:50 PM | |
| | 4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 413 22 3601 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) May 22 1921 | |
| | 9. Birthplace (State or Foreign Country) Texas | | 10a. State Md. | | 10b. County Montgomery | | 10c. City, Town or Location Derwood | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 17100 Overhill Road | | 10f. Zip Code 20855 | |
| | 10g. Citizen of What Country? United States | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | | 16b. Kind of Business/Industry Health Institute | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Earl William Parker | | | | 18. Mother's Name (First, Middle, Maiden Surname) Alma Elizabeth Moore | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Floyd R. Lashmit / Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17100 Overhill Road, Derwood, Md. 20855 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Cemetery | | 20c. Location - City or Town, State Rockville, Md. | |
| | 21. Signature of Funeral Service Licensee Muriel H. Barber | | | | 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic obstructive pulmonary disease | | | | 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. Date of delivery Month Day Year | |
| | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure, atrial fibrillation Severe arthritis - bedbound | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) April 24 2004 | | | |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury M | | | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| | 29b. Signature and title of certifier Alan S. Chanaler | | | | 29c. License number 29453 | | | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year) April 25, 2004 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN CHANALER 15115 SHADY GROVE RD ROCKVILLE MD 20850 | | | |
| | 31. Date filed (Month, Day, Year) APR 28 2004 | | | | 32. Registrar's Signature [Signature] | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

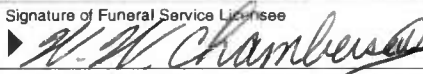
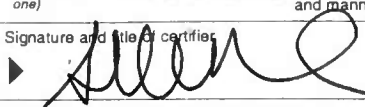
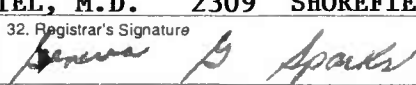
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 15272

| | | | | | | | | |
|--|--|---|---|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGE H. LAWLER | | | | 2. Date of Death Month APRIL Day 21 Year 2004 | | 3. Time of Death 5:00 A M | |
| | 4a. Facility Name (If not institution, give street and number) HOLY CROSS REHAB. & NURSING CENTER | | | | 4b. City, Town, or Location of Death BURTONSVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 423-50-8011 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) SEPT. 6, 1937 | |
| | 9. Birthplace (State or Foreign Country) ALABAMA | | 10a. State NC | | 10b. County CUMBERLAND | | 10c. City, Town or Location FAYETTEVILLE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1717A SHAW RD. | | 10f. Zip Code 28311 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1962-1965 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINIST | | 16b. Kind of Business/Industry KELLY SPRINGFIELD CO. | | | |
| | 17. Father's Name (First, Middle, Last) NELSON LAWLER | | | | 18. Mother's Name (First, Middle, Maiden Surname) EULA MAE TAYLOR | | | |
| | 19a. Informant's Name/Relationship (Type, Print) PAMELA LAWLER/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 ROBEY TERR. #304, SILVER SPRING, MD. 20904 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY | | 20c. Location - City or Town, State 4-22-2004 RIVERDALE, MD. | | | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PNEUMONIA Due to (or as a consequence of): b. LUNG CANCER Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D0058962 | | 29d. Date signed (Month, Day, Year) APRIL 21, 2004 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASHANK G. PATEL, M.D. 2309 SHOREFIELD RD., WHEATON, MD. 20902 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15273

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SAUL

LEW

2. Date of Death

Month

Day

Year

APRIL 22, 2004

3. Time of Death

6:00 P^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

100-14-2923

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

11/20/1922

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6105 MONTROSE ROAD #3119

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER

16b. Kind of Business/Industry

FURNITURE MANUFACTURER

17. Father's Name (First, Middle, Last)

JOSEPH

LEW

18. Mother's Name (First, Middle, Maiden Surname)

ROSA

BECKER

19a. Informant's Name/Relationship (Type, Print)

LINDA WEINSTEIN/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13511 CEDAR CREEK LANE, SILVER SPRING, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ARARAT CEMETERY

Date

04/25/2004

20c. Location - City or Town, State

LONG ISLAND, NEW YORK

21. Signature of Funeral Service Licensee

Amanda Ludwig

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ischemic heart disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive pulmonary disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gary B. Wilks, M.D.

29c. License number

D 55258

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary B. Wilks, M.D. 6121 Montrose Road Rockville Maryland 20852

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Annette B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15274

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jerry Lobel

2. Date of Death

Month

Day

Year

3. Time of Death

2:32 AM

4a. Facility Name (If not institution, give street and number)

14112 Laurel Avenue

4b. City, Town, or Location of Death

Ocean City

4c. County of Death

Worcester

5. Social Security Number

579-36-4055

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 30, 1929

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10900 Coastal Highway #305

10f. Zip Code

21842

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Businessman

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Abraham Lobel

18. Mother's Name (First, Middle, Maiden Surname)

Rachel Shimonowitz

19a. Informant's Name/Relationship (Type, Print)

Amy Fadida, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14112 Laurel Avenue, Ocean City, MD 21842

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King David Memorial Garden

Date

04/27/04

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Services Licensee

22. Name and Address of Facility

Torchinsky Hebrew Funeral Home

254 Carroll St., NW, Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Bladder Cancer

Due to (or as a consequence of):

Proximate Interval Between Onset and Death

10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Daughter's Residence

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

030690

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James E. MARTIN, M.D. 145 E Carroll St., Salisbury, MD 21801

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

James E. Martin

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15275

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROLAND M. LLOYD, SR.

2. Date of Death

Month
APRILDay
22Year
2004

3. Time of Death

6:45PM M

4a. Facility Name (If not institution, give street and number)

MALLARD BAY CARE CENTER

4b. City, Town, or Location of Death

CAMBRIDGE

4c. County of Death

DORCHESTER

5. Social Security Number

213-14-1178

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 13 1917

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

NEWCOMB

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7398 BACK STREET

10f. Zip Code

21653

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ NoIf Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ELECTRICAL ENGINEER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

LAFAYETTE LANGRALL LLOYD

18. Mother's Name (First, Middle, Maiden Surname)

MARY CREIGHTON

19a. Informant's Name/Relationship (Type, Print)

DIANE L. RICHARDSON/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7598 BLUEBERRY ACRES RD., ST. MICHAELS, MD 21663

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

WOODLAWN MEMORIAL PARK 4-27-2004

Date

20c. Location - City or Town, State

EASTON, MARYLAND

21. Signature of Funeral Service Licensee

JOHN R. MERCER

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A.

200 S. HARRISON ST EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Carcinoma of Lung

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?☐ Yes ☐ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an
autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accidental☐ Suicide☐ Homicide☐ Pending
investigation☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D0056659

29d. Date signed (Month, Day, Year)

4/26/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUHAMMAD AFZAL 300 ACROKAT ST, CAMBRIDGE MD - 21613

31. Date filed (Month, Day, Year)

APR 27 2004

Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
202-691-0054.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15276

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Blanche Mary Montgomery

2. Date of Death
Month
Day
Year

04

29

04

3. Time of Death

2:58a M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

5. Social Security Number

219-56-0328

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

8. Date of Birth (Month, Day, Year)

Dec. 9, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Nanjemoy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10810 Gethsemane Road

10f. Zip Code

20662

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Food Service Contractor

17. Father's Name (First, Middle, Last)

William Warren

18. Mother's Name (First, Middle, Maiden Surname)

Mary Carroll

19a. Informant's Name/Relationship (Type, Print)

Joseph Montgomery Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10810 Gethsemane Rd., Nanjemoy, Md. 20662

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

May 4, 2004

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

M00668

22. Name and Address of Facility

Williams Funeral Home, P.A.
4270 Hawthorne Rd., Indian Head, Md. 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M00668

29c. License number

D-21031

29d. Date signed (Month, Day, Year)

4/29/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael A. Leatherwood, MD 12070 Old Line Center Waldorf, MD 20602

State
Registrar

31. Date filed (Month, Day, Year)

MAY 03 2004

32. Registrar's Signature

M00668

Blanche Montgomery
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15277

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | |
|---|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last) DENISE MARGARET MANGINO | | 2. Date of Death Month Day Year MAY 4, 2004 | | 3. Time of Death 1:00 PM | |
| 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death | |
| 5. Social Security Number 074-34-7277 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 61 Yrs. | 8. Date of Birth (Month, Day, Year) OCT 9, 1942 | | 9. Birthplace (State or Foreign Country) NEW YORK |
| Usual Residence of Decedent | | | | | |
| 10a. State MARYLAND | | 10b. County BALTIMORE | | 10c. City, Town or Location OWINGS MILLS | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 4813 SHELLBARK ROAD | | 10f. Zip Code 21117 | | 10g. Citizen of What Country? UNITED STATES | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LICENSED PRACTICAL NURSE | | 16b. Kind of Business/Industry HOSPITAL | |
| 17. Father's Name (First, Middle, Last) LOUIS LOCHARD | | | 18. Mother's Name (First, Middle, Maiden Surname) MARGARET CALLAHAN | | |
| 19a. Informant's Name/Relationship (Type, Print) CHERIE A. BEATTY/DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9400 CANDLEBERRY CT, BURKE, VA 22015 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CARROLL CREMATION | | 20c. Location - City or Town, State HAMPSTEAD, MARYLAND | |
| 20d. Date 5/8/2004 | | | | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, MD 21157 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ISCHEMIC BOWEL Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | Approximate Interval Between Onset and Death |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D0055119 | | 29d. Date signed (Month, Day, Year) MAY 4, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS GENUIT, MD, SINAI HOSPITAL OF BALTIMORE | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, this Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

PATIENT known AS Denise M Mangino * 10/09/42
Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15278

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel Estelle Michael

2. Date of Death

May 1, 2004

3. Time of Death

7:30 P M

4a. Facility Name (If not institution, give street and number)

2160 Pineview Court

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

577-32-8447

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Apr. 20, 1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2160 Pineview Court

10f. Zip Code

20601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Postal Service

17. Father's Name (First, Middle, Last)

Oscar Melvin King

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Miller Balderson

19a. Informant's Name/Relationship (Type, Print)

Warren C. Michael - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2160 Pineview Ct., Waldorf, MD 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Cemetery 5-5-04

Date

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

M01391

22. Name and Address of Facility

Huntt Funeral Home
P. O. Box 156, Waldorf, MD 2060423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. END STAGE CHRONIC Obstructive
pulmonary disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

YRS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MAY 3, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHVIN J. PATEL, MD, 102 PAUL MELLON CT., #102, WALDORF, MD 20602

31. Date filed (Month, Day, Year)

MAY 04 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15279

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Samuel M. Maddox, Jr.

2. Date of Death

Month Day Year
April 24, 2004

3. Time of Death

2:55am M

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

417-48-8689

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 3, 1935

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6 Mastenbrook Court

10f. Zip Code

20886

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Black15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mathematician

16b. Kind of Business/Industry

IBM

17. Father's Name (First, Middle, Last)

Samuel M. Maddox, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ernestine Jones

19a. Informant's Name/Relationship (Type, Print)

Jessie S. Maddox (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Mastenbrook Court, Montgomery Village, MD 20886

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lincoln Memorial Cem.

Date

4/29/2004

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home
10 East Deer Park Drive
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Prostate Cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 Year

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Renal Failure

Due to (or as a consequence of):

6 Months

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0061083

29d. Date signed (Month, Day, Year)

APRIL 24, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul M. thambi, MD 9707 Medical Center Drive #30, Rockville, MD 20850

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15280

1- For
State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Eugene F. Maholchic | | | | 2. Date of Death Month Day Year April 21, 2004 | | 3. Time of Death 11:35 A^M | |
| 4a. Facility Name (If not institution, give street and number) Montgomery General Hospital | | | | 4b. City, Town, or Location of Death Olney | | 4c. County of Death Montgomery | |
| 5. Social Security Number 179-16-3978 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) July 13, 1924 | |
| 9. Birthplace (State or Foreign Country) Pennsylvania | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 14208 Chelmsford Road | | | | 10f. Zip Code 20853 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contract Administrator | | 16b. Kind of Business/Industry U.S. Government | |
| 17. Father's Name (First, Middle, Last) George Maholchic | | | | 18. Mother's Name (First, Middle, Maiden Surname) Claire Wasley | | | |
| 19a. Informant's Name/Relationship (Type, Print) Irene Maholchic / Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14208 Chelmsford Road Rockville, Maryland 20853 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date April 26, 2004 | | 20c. Location - City or Town, State Silver Spring, MD | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Pulmonary Mass with Partial Bronchial Obstruction Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| Approximate Interval Between Onset and Death 4 Days 11 Months | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type II Diabetes Mellitus Vasculitis Prostate Cancer | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D 35045 | | 29d. Date signed (Month, Day, Year) April 22, 2004 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip G. Henjum, M.D., 3416 Olandwood Court, #204, Olney, Maryland 20832 | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature  | | | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15281

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Corinne Heurich Martin

2. Date of Death

Month Day Year
April 26, 2004

3. Time of Death

8:20 p M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda, MD

4c. County of Death

Montgomery

5. Social Security Number

579-28-9795

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 2, 1926

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5837 Marbury Road

10f. Zip Code

20817

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Christian Heurich, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Consuelo Young

19a. Informant's Name/Relationship (Type, Print)

James C. Martin husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5837 Marbury Rd. Bethesda, MD 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rock Creek Cemetery

Date

May 3, 2004

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Joseph Gawler's Sons, Inc.
5130 Wisconsin Ave. NW Washington, DC 2001623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

RESPIRATORY FAILURE

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

SEVERE CHRONIC OBSTRUCTIVE AIRWAYS DISEASE

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

EMPHYSEMA, ILEUS, NEUROPATHY OF
CRITICAL ILLNESS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of Certifier

29c. License number

D26571

29d. Date signed (Month, Day, Year)

4/27/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Irving Mizus, MD 10215 Fernwood Rd. Bethesda, MD 20817

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitMartin, Corinne H
4/26 8:20 PM
Division of Vital Records, P.O. Box 68760,State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No.

2004 15282

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAYNE E. MARTIN

2. Date of Death

Month Day Year
APRIL 26, 2004

3. Time of Death

12:40 A M

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

279-18-1882

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 2, 1917

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☐ Yes 2 ☒ No

10e. Street and Number

4704 MACON RD.

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

ALBERT H. KRAPP

18. Mother's Name (First, Middle, Maiden Summa)

ELIZABETH HOMEGARDNER

19a. Informant's Name/Relationship (Type, Print)

GAYLE SCOTT/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4704 MACON RD., ROCKVILLE, MD. 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

MEADOW GREEN CEMETERY 4-29-04

20c. Location - City or Town, State

HURON, OHIO

21. Signature of Funeral Service Licensee

M. H. Chambers M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 2073723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

b. MULTI INFARCT DEMENTIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

MINS.

YRS.

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. NAWAZ

29c. License number

DS0987

29d. Date signed (Month, Day, Year)

APRIL 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHMED NAWAZ, M.D.

PO BOX 20819, GAITHERSBURG, MD. 20883

State
Registrar

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Benita Sparks

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15283

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Theodore Mason

2. Date of Death

Month Day Year
April 24, 2004

3. Time of Death

5:15 am

4a. Facility Name (If not institution, give street and number)

12609 Steeple Chase Way

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

067-26-5294

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 29, 1937

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12609 Steeple Chase Way

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Executive

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Theodore Mason

18. Mother's Name (First, Middle, Maiden Surname)

Millicent Carpenter

19a. Informant's Name/Relationship (Type, Print)

Joan M. Mason/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12609 Steeple Chase Way, Potomac, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Gate of Heaven
Cemetery

Date

April 28,
2004

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Esophageal Cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 Months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George A. Sotos

29c. License number

D43083

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George A. Sotos M.D. 9707 Medical Center Drive, #300, Rockville, MD 20850

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15284

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Mildred T. McCool | | 2. Date of Death Month Day Year April 24, 2004 | | 3. Time of Death 10:52 P^M | |
| 4a. Facility Name (If not institution, give street and number) 4022 Decatur Avenue | | 4b. City, Town, or Location of Death Kensington | | 4c. County of Death Montgomery | |
| 5. Social Security Number 201-10-4505 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | 8. Date of Birth (Month, Day, Year) April 8, 1919 | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| Usual Residence of Decedent | | | | | |
| 10a. State D.C. | 10b. County None | 10c. City, Town or Location Washington | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 3806 W Street, NW | | 10f. Zip Code 20007 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) _____ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | 16b. Kind of Business/Industry Georgetown University Dental School | |
| 17. Father's Name (First, Middle, Last) Louis Guiteras | | | 18. Mother's Name (First, Middle, Maiden Surname) Jeanette Ryan | | |
| 19a. Informant's Name/Relationship (Type, Print) Jeanette McCool/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1713 Dublin Drive, Silver Spring, Md. 20902 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem. | | 20c. Location - City or Town, State Silver Spring, Md. | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Breast Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death 3 years |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive Cardiovascular Disease | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Son's residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D26331 | | 29d. Date signed (Month, Day, Year) April 26, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marta A. Schneider, M.D., 5401 MacArthur Blvd., NW, Washington, DC 20016 | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15285

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Margaret Sarah McDaniel | | | | 2. Date of Death Month Day Year April 19, 2004 | | 3. Time of Death 8:55 P.M. | |
| 4a. Facility Name (If not institution, give street and number) Wilson Health Care Center | | | | 4b. City, Town, or Location of Death Gaithersburg | | 4c. County of Death Montgomery | |
| 5. Social Security Number 577-01-7618 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Aug. 15, 1911 | |
| 9. Birthplace (State or Foreign Country) Missouri | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 403 Russell Avenue, # 409 | | | | 10f. Zip Code 20877 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk | | 16b. Kind of Business/Industry U.S. District Court | |
| 17. Father's Name (First, Middle, Last) Joseph C. Phillips | | | | 18. Mother's Name (First, Middle, Maiden Sumame) Mary Russell Fearnow | | | |
| 19a. Informant's Name/Relationship (Type, Print) Janice Didawick/ Cousin | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 615, Berkeley Springs, WV 25411 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | Date 4/23/2004 | | 20c. Location - City or Town, State Suitland, Maryland | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. dementia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Approximate Interval Between Onset and Death years | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | | | | |
| 29c. License number D-20148 | | 29d. Date signed (Month, Day, Year) April 20, 2004 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Dolinsky mo 911 Russell Avenue Gaithersburg Md 20877 | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature  | | | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15286

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 955A.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Pauline L. McKinstry | | 2. Date of Death Month April Day 26 Year 2004 | | 3. Time of Death 2:35 A M | |
| 4a. Facility Name (If not institution, give street and number) Brooke Grove Rehabilitation & Nursing Center | | 4b. City, Town, or Location of Death Sandy Spring | | 4c. County of Death Montgomery | |
| 5. Social Security Number 220-38-2582 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 91 Yrs. | 8. Date of Birth (Month, Day, Year) June 5, 1912 | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Montgomery | 10c. City, Town or Location Rockville | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 13609 Loree Lane | | 10f. Zip Code 20853 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Head Mistress | | 16b. Kind of Business/Industry Church School | |
| 17. Father's Name (First, Middle, Last) William Leshner | | | 18. Mother's Name (First, Middle, Maiden Surname) Ada Smith | | |
| 19a. Informant's Name/Relationship (Type, Print) Thomas A. McKinstry/Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6600 Griffith Road, Laytonsville, Maryland 20882 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. | | 20c. Location - City or Town, State Bethesda, Maryland | |
| 21. Signature of Funeral Service Licensee [Signature] M00803 | | 22. Name and Address of Facility Robert A. Humphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE CEREBRAL INFARCT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 weeks | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier [Signature] MD | | 29c. License number D33700 | | 29d. Date signed (Month, Day, Year) APRIL 26, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TED HOWE 154 N. ARTISAN ST. WILLIAMSPORT, MD 21795 | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | 32. Registrar's Signature [Signature] | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15287

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cleo B. Morrill

2. Date of Death

Month Day Year
April 23, 2004

3. Time of Death

12:19A. M

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

218-20-1122

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 26, 1910

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2012 Brighton Road

10f. Zip Code

20782

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Analyst

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Henry D. Morrill

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Susan Borst

19a. Informant's Name/Relationship (Type, Print)

Mildred L. Morrill -wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2012 Brighton Road Hyattsville, Maryland 20782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery 4/26/2004

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

K. R. Thomas

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
3 DaysSequentially list conditions,
if any, leading to immediate
cause. Enter underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

unknown

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspirin pneumonia
Chronic obstructive Pulmonary disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

B. F. Reagan MD

29c. License number

D00045121

29d. Date signed (Month, Day, Year)

April 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN F. REAGAN

7600 Carroll Ave
Takoma Park, MarylandState
Registrar

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

B. F. Reagan

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15288

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) John Hallett Mulliken, Jr. | | 2. Date of Death Month Day Year April 28, 2004 | | 3. Time of Death 5:10 PM^M | |
| 4a. Facility Name (If not institution, give street and number) 5630 Wisconsin Avenue #301 | | 4b. City, Town, or Location of Death Chevy Chase | | 4c. County of Death Montgomery | |
| 5. Social Security Number 109-16-3865 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | |
| 8. Date of Birth (Month, Day, Year) July 17, 1922 | | 9. Birthplace (State or Foreign Country) Illinois | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Chevy Chase | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 5630 Wisconsin Avenue #301 | | 10f. Zip Code 20815 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Journalist | | 16b. Kind of Business/Industry Publishing | |
| 17. Father's Name (First, Middle, Last) John Hallett Mulliken, Sr. | | | 18. Mother's Name (First, Middle, Maiden Surname) Pauline Miller | | |
| 19a. Informant's Name/Relationship (Type, Print) Helen Burr Curtice/Stepdaughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5164 Fulton Street N.W. Washington, D.C. 20016 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium Inc. | | 20c. Location - City or Town, State Bethesda, Maryland | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Myeloma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | |
| 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | | |
| 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D22086 | | 29d. Date signed (Month, Day, Year) April 29, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick P. Smith, M.D. 5454 Wisconsin Avenue #1300 Chevy Chase, Maryland 20815 | | | | | |
| 31. Date filed (Month, Day, Year) APR 30 2004 | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12-1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15289

1- For
State
Registrar

| | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GRETIA FREDERICKSON MCCASH | | | | | | 2. Date of Death Month Day Year APRIL 27 2004 | | 3. Time of Death Day Year 22:10 M | |
| | 4a. Facility Name (If not institution, give street and number) DORCHESTER GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death CAMBRIDGE | | | 4c. County of Death DORCHESTER | | |
| Funeral Director | 5. Social Security Number 508-07-5548 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) AUG 17 1921 | | 9. Birthplace (State or Foreign Country) NEBRASKA | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County TALBOT | | 10c. City, Town or Location EASTON | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 640 MECKLENBURG AVE. | | | | 10f. Zip Code 21601 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COMESTICIAN | | | 16b. Kind of Business/Industry DRUG STORE | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) TOM FREDERICKSON | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) IVA L. SCHLISLER | | | |
| | 19a. Informant's Name/Relationship (Type, Print) S.W. MCCASH/SON | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28468 CLUBHOUSE DRIVE EASTON, MARYLAND 21601 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR 4-28-2004 | | 20c. Location - City or Town, State STEVENSVILLE, MD | | 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 | | | |
| | 21. Signature of Funeral Service Licensee JOHN R. MERCERON | | | | | | 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease a. Due to (or as a consequence of): Chronic Tobacco Use b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Michael P. Moran MD | | 29c. License number D36860 | | 29d. Date signed (Month, Day, Year) 4/28/04 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL P. MORAN, MD 2 AURORA ST CAMBRIDGE, MD 21613 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) APR 28 2004 | | | | 32. Registrar's Signature John B. Spivey | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15290

1- For
State
Registrar

| | | | | | | | | | | |
|--|---|--|---|---|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles Loren Madigan | | | 2. Date of Death Month April Day 25 Year 2004 | | | 3. Time of Death 8:00 A M | | | |
| | 4a. Facility Name (If not institution, give street and number) 16 Congress Avenue | | | 4b. City, Town, or Location of Death Deer Park | | | 4c. County of Death Garrett | | | |
| Funeral Director | 5. Social Security Number 214-16-2458 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) April 28, 1920 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | 10a. State MD | | | 10b. County Garrett | | | 10c. City, Town or Location Deer Park | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 16 Congress Avenue | | | 10f. Zip Code 21550 | | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) Foreman | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | | 16b. Kind of Business/Industry B.O. railroad | | | | |
| 17. Father's Name (First, Middle, Last) Charles Henry Madigan | | | 18. Mother's Name (First, Middle, Maiden Surname) Carrie Mae Hinebaugh | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Alice M. Madigan/daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Congress Avenue, Deer Park, Md. 21550 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Deer Park Cemetery | | | Date 4/28/04 | | 20c. Location - City or Town, State Deer Park, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Due to (or as a consequence of): Diabetes Mellitus Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death Years | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | | 23d. Date of delivery Month Day Year | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier | | | 29c. License number D15333 | | | 29d. Date signed (Month, Day, Year) 4/28/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, M.D. 311 N. 4th St., Oakland, Md. 21550 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15291

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Joel Benjamin Miller | | | | 2. Date of Death Month 04 Day 22 Year 04 | | 3. Time of Death 13:10 M | |
| 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegheny | |
| 5. Social Security Number 218-64-9152 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 51 Yrs. | | 8. Date of Birth (Month, Day, Year) July 22, 1952 | |
| 9. Birthplace (State or Foreign Country) Pennsylvania | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Garrett | | 10c. City, Town or Location Grantsville | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1167 Springs Road | | | | 10f. Zip Code 21536 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Laborer | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry Retail Store/Yoder's Locker | |
| 17. Father's Name (First, Middle, Last) Daniel M. Miller | | | | 18. Mother's Name (First, Middle, Maiden Surname) Grace M. Schrock | | | |
| 19a. Informant's Name/Relationship (Type, Print) Daniel M. Miller/father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 186 Coal Run Road, Meyersdale, PA 15552 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cherry Glade Cemetery | | Date 2004 | | 20c. Location - City or Town, State Accident, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275; Grantsville, Maryland 21536 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BILA TERAL PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last CONGESTIVE HEART FAILURE MORBID OBESITY ACUTE RENAL FAILURE | | | | | | | |
| 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | | | | |
| 23d. Date of delivery Month Day Year | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE MORBID OBESITY ACUTE RENAL FAILURE | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D50931 | | 29d. Date signed (Month, Day, Year) APRIL 22, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIRGINIA G. MABBOLOS, MD 912 JETON DRIVE CUMBERLAND, MD 21001 | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | | | 32. Registrar's Signature | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar


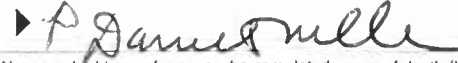
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15292

1- For
State
Registrar

| | | | | | | |
|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EUGENIE (NMI) MAC FARLINE | | 2. Date of Death Month Day Year APRIL 25, 2004 | | 3. Time of Death 9:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) 2026 SPRING LICK ROAD | | 4b. City, Town, or Location of Death SWANTON | | 4c. County of Death GARRETT | |
| Funeral Director | 5. Social Security Number 141-24-5781 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | 8. Date of Birth (Month, Day, Year) OCT 13, 1925 | 9. Birthplace (State or Foreign Country) GERMANY | |
| | Usual Residence of Decedent | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County GARRETT | 10c. City, Town or Location SWANTON | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 2026 SPRING LICK ROAD | | 10f. Zip Code 21561 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | |
| | 16b. Kind of Business/Industry OWN HOME | | 17. Father's Name (First, Middle, Last) (UNKNOWN) DIETZEL | | 18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN) | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) CYNTHIA MOONEY - DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3356 WYE MILLS S. LAUREL, MD 20724 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) OMEGA CREMATORY | | 20c. Location - City or Town, State 4/27/04 MORGANTOWN, WV | |
| | 21. Signature of Funeral Service Licensee  MO0167 | | 22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCLEROTIC CORONARY VASCULAR DISEASE | | Approximate Interval Between Onset and Death YEARS | | | |
| | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number H26154 | | 29d. Date signed (Month, Day, Year) APRIL 26, 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. DANIEL MILLER, D.O. 69 WOLF ACRES DRIVE OAKLAND, MD 21550 | | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15293

1- For
State
Registrar

| | | | | | |
|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GEORGE A. NITZ | | 2. Date of Death Month Day Year May 2, 2004 | | 3. Time of Death 9:35 a.m. |
| | 4a. Facility Name (If not institution, give street and number) Univ. of Maryland Medical Syst. | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death |
| Funeral Director | 5. Social Security Number 223-10-9701 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 90 Yrs. | 8. Date of Birth (Month, Day, Year) March 2, 1914 | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Cecil | 10c. City, Town or Location Conowingo | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 205 Frock Lane | | 10f. Zip Code 21918 | | 10g. Citizen of What Country? United States |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Water Plant Operations | | 16b. Kind of Business/Industry U.S. Government | | |
| | 17. Father's Name (First, Middle, Last) Harry Nitz | | 18. Mother's Name (First, Middle, Maiden Surname) Caroline Bland | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Robert Nitz / Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 256 Frock Lane, Conowingo, MD 21918 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) High View Memorial Gardens | | 20c. Location - City or Town, State May 7, 2004 Fallston, Maryland |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Richard L. Goodie | | 22. Name and Address of Facility R.T. Foard Funeral Home, P/A. 111 South Queen St., Rising Sun, MD 21911 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Perforated Gastric Ulcer Due to (or as a consequence of): b. Multi-System Organ Failure Due to (or as a consequence of): c. Necrotizing Small Bowel Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | |
| | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier A. Chen | | 29c. License number D60147 | | 29d. Date signed (Month, Day, Year) May 4, 2004 |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aaron Chen, MD 22 S. Greene Street., Baltimore, Md 21201 | | | | |
| | 31. Date filed (Month, Day, Year) MAY 4 2004 | | 32. Registrar's Signature [Signature] | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

104 IVA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15294

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last) Robert Luverne Nair | | 2. Date of Death Month Apr Day 29 Year 2004 | | 3. Time of Death 1:00 pm M | |
| 4a. Facility Name (If not institution, give street and number) 1009 Virginia Avenue | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| 5. Social Security Number 223-36-6909 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 73 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jun 9, 1930 |
| 9. Birthplace (State or Foreign Country) IA | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County Allegany | 10c. City, Town or Location Cumberland | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1009 Virginia Avenue | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Ministry | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ministry | | 16b. Kind of Business/Industry Ministry | | | |
| 17. Father's Name (First, Middle, Last) Benjamin Harrison Nair | | | 18. Mother's Name (First, Middle, Maiden Surname) Edith Faye Nair | | |
| 19a. Informant's Name/Relationship (Type, Print) Arettia Nair wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 Virginia Avenue Cumberland MD 21502 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Scarpelli Funeral Home, P.A. | | 20c. Location - City or Town, State Cresaptown MD | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 108 Virginia Avenue, Cumberland, MD 21502 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | |
| a. Acute renal Failure | | | | | |
| Due to (or as a consequence of): | | | | | |
| b. Rhabdomyolysis | | | | | |
| Due to (or as a consequence of): | | | | | |
| c. Acute Arterial occlusion LEG | | | | | |
| Due to (or as a consequence of): | | | | | |
| d. | | | | | |
| Approximate Interval Between Onset and Death Weeks | | | | | |
| IF FEMALE: | | | | | |
| 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D54756 | | 29d. Date signed (Month, Day, Year) April 30 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Rapp M.D. 912 Seton Drive Cumberland MD 21502 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15295

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Janaka Bandara Nakkawita

2. Date of Death

Month Day Year
April 27, 2004

3. Time of Death

8:11 P^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

6115 Bradley Boulevard

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

None

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 29, 1941

9. Birthplace (State or Foreign Country)

Sri Lanka

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6115 Bradley Boulevard

10f. Zip Code

20817

10g. Citizen of What Country?

Sri Lanka

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Asian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Diplomat

16b. Kind of Business/Industry

Embassy

17. Father's Name (First, Middle, Last)

Charles Nakkawita

18. Mother's Name (First, Middle, Maiden Surname)

Anula Kuruppu

19a. Informant's Name/Relationship (Type, Print)

Rohini Nakkawita/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6115 Bradley Blvd., Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Montgomery Crematorium

Date

April 29,
2004

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc.
7557 Wisconsin Ave., Bethesda, MD 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Metastatic Lung Cancer

Approximate
Interval Between
Onset and Death

6 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

MD0033293

29d. Date signed (Month, Day, Year)

April 28, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick P. Smith, M.D. 5454 Wisconsin Ave., #1300, Chevy Chase, Maryland 20815

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show
any injury, or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15296

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Philip Carroll Nicholson, Jr. | | | | 2. Date of Death Month Day Year April 22, 2004 | | 3. Time of Death 6:50 a m | |
| 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| 5. Social Security Number 578-03-3068 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) June 25, 1922 | |
| 9. Birthplace (State or Foreign Country) Washington, DC | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1102 Claggett Drive | | 10f. Zip Code 20851 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Network Technician | | 16b. Kind of Business/Industry Telephone Company | | 17. Father's Name (First, Middle, Last) Philip Carroll Nicholson, Sr. | |
| 18. Mother's Name (First, Middle, Maiden Surname) Margaret Clements | | 19a. Informant's Name/Relationship (Type, Print) Jessamine V. Nicholson/ Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1102 Claggett Drive, Rockville, MD 20851 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery | | 20c. Date April 27 2004 | | 20d. Location - City or Town, State Brentwood, Maryland | | 21. Signature of Funeral Service Licensee | |
| 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia | | 23b. Immediate Cause (Final disease or condition resulting in death) | | Approximate Interval Between Onset and Death 2 weeks | |
| 23c. Due to (or as a consequence of): | | 23d. Due to (or as a consequence of): | | 23e. Due to (or as a consequence of): | | 23f. Due to (or as a consequence of): | |
| 23g. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease | | 23g. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23h. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23i. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 23j. Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 23k. Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 23l. Place of Death (Check only one) | | 23m. 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | |
| 23n. 28a. Date of Injury (Month, Day Year) | | 23o. 28b. Time of Injury M | | 23p. 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23q. 28d. Describe how injury occurred | |
| 23r. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 23s. 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 23t. 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 23u. 29b. Signature and title of certifier | |
| 23v. 29c. License number D42518 | | 23w. 29d. Date signed (Month, Day, Year) APRIL 22, 2004 | | 23x. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. CHABIAN, 1119 Rockville Pike #401 Rockville MD 20852 | | 23y. 31. Date filed (Month, Day, Year) APR 27 2004 | |
| 23z. 32. Registrar's Signature | | | | | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15297

1- For
State
Registrar

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BLANCHE W. NIMETZ | | | | 2. Date of Death Month Day Year APRIL 27, 2004 | | 3. Time of Death 2:20 AM | |
| | 4a. Facility Name (If not institution, give street and number) 5225 POOKS HILL ROAD | | | | 4b. City, Town, or Location of Death BETHESDA | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 578-62-7146 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) JANUARY 7, 1914 | |
| | 9. Birthplace (State or Foreign Country) WASHINGTON, DC | | 10a. State MARYLAND | | 10b. County MONTGOMERY | | 10c. City, Town or Location BETHESDA | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 5225 POOKS HILL ROAD #613S | | 10f. Zip Code 20814 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PHYSICIAN | | 16b. Kind of Business/Industry MEDICAL | | | |
| | 17. Father's Name (First, Middle, Last) LOUIS WIDOME | | | | 18. Mother's Name (First, Middle, Maiden Surname) KATE PEARSON | | | |
| | 19a. Informant's Name/Relationship (Type, Print) DR. ALLEN A. NIMETZ-SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8116 SPLIT OAK DRIVE, BETHESDA, MARYLAND 20817 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH SHOLOM CONG. CEM | | 20c. Location - City or Town, State CAPITOL HEIGHTS, MD | | Date 4/29/2004 | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC VAGINAL MALIGNANT MELANOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | | | | | | |
| | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | | | | |
| 23d. Date of delivery Month Day Year | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23a. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | |
| | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier | | 29c. License number D33554 | | 29d. Date signed (Month, Day, Year) APRIL 28, 2004 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JOHN YERG, 5410 CONNECTICUT AVENUE, #1170, NW, WASHINGTON, D.C. 20016 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) APR 30 2004 | | | | 32. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15298

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS CRAIG O'DONNELL

2. Date of Death
Month Day Year
April 29, 2004

3. Time of Death
859 a M

4a. Facility Name (If not institution, give street and number)

936 Kimberly Way

4b. City, Town, or Location of Death

Stevensville

4c. County of Death

Queen Anne's

Funeral
Director

5. Social Security Number
215-62-0901

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
50 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
JAN. 15, 1954

9. Birthplace (State or Foreign Country)
MARYLAND

Usual Residence of Decedent

10a. State
MD

10b. County
QUEEN ANNE'S

10c. City, Town or Location
STEVENSVILLE

10d. Inside City Limits
1 ☒ Yes 2 ☐ No

10e. Street and Number

936 KIMBERLY WAY

10f. Zip Code

21666

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.
Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)
—0—

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

HOME IMPROVEMENT

17. Father's Name (First, Middle, Last)

THOMAS VERNON O'DONNELL

18. Mother's Name (First, Middle, Maiden Surname)

EVELENE BICKFORD

19a. Informant's Name/Relationship (Type, Print)

DIXIE LEE REICHEL/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

936 KIMBERLY WAY, STEVENSVILLE, MD 21666

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Date

05/01/2004

20c. Location - City or Town, State

STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Drowning
Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

3 ☐ Ectopic pregnancy
5 ☐ Other (Specify)

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
2 ☒ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury
(Month, Day Year)
Found 4-29-04

28b. Time of
Injury
8:50 AM

28c. Injury at
Work?
1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)
home

28d. Describe how injury occurred

Decedent drowned

28f. Location (Street and Number or Rural Route Number,
City or Town, State) 936 Kimberly Way
Stevensville, MD 21666

29a. Certifier
(Check only
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

OCME

29d. Date signed (Month, Day, Year)

April 30, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. R. HOGAN

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY - 3 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15299

1- For State Registrar

| | | | | | | | | |
|---|--|---|--|--|---|---|---|--|
| Physician / Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM WESLEY PEAKER, SR. | | | | 2. Date of Death Month APRIL Day 29 Year 2004 | | 3. Time of Death 10:50 AM | |
| | 4a. Facility Name (If not institution, give street and number) HARFORD MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death HAVRE DE GRACE | | 4c. County of Death HARFORD | |
| Funeral Director | 5. Social Security Number 219-14-0419 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV 1, 1926 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Belcamp | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1123 Belcamp Garth | | 10f. Zip Code 21017 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Worker | | 16b. Kind of Business/Industry City of Aberdeen | | | | |
| 17. Father's Name (First, Middle, Last) Samuel Peaker | | 18. Mother's Name (First, Middle, Maiden Surname) Geraldine Beasley | | 19a. Informant's Name/Relationship (Type, Print) Idella Peaker / daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 Crimson Tree Way, Edgewood, MD 21040 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) John Wesley U. M. Cem | | 20c. Location - City or Town, State Abingdon, Maryland | | 20d. Date 5/4/04 | | |
| 21. Signature of Funeral Service Licensee Lisa Scott | | 22. Name and Address of Facility Lisa Scott Funeral Home, P.A. 552 Lewis Street, Havre de Grace, MD 21078 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Coronary artery disease b. recent myocardial infarction c. Diabetes Mellitus d. peripheral vascular disease | | Approximate Interval Between Onset and Death | | |
| 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) 5/4/04 | | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier J. T. Lee | | 29c. License number D20661 | | |
| 29d. Date signed (Month, Day, Year) 5/9/04 | | 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) J. T. Lee MD, 669 Revolution St. Havre de Grace MD, 21078 | | 31. Date filed (Month, Day, Year) MAY 3 2004 | | 32. Registrar's Signature [Signature] | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15300

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Rowland Packard

2. Date of Death

Month 4 Day 30 Year 2004

3. Time of Death

00:20 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

218-46-4989

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

May 14, 1952

9. Birthplace (State or Foreign
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

981 Chesapeake Drive

10f. Zip Code

21078

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
Twelve Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Never Employed

16b. Kind of Business/Industry

Never Employed

17. Father's Name (First, Middle, Last)

Wallace M. Rowland, II

18. Mother's Name (First, Middle, Maiden Surname)

Mary Warrington

19a. Informant's Name/Relationship (Type, Print)

Wallace M. Rowland, II

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8800 Walther Blvd., Apt. 3601, Baltimore, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

R.A. Ferris & Co., Inc.

Date

05/02/04

20c. Location - City or Town, State

West Chester, Pennsylvania

21. Signature of Funeral Service Licensee

Theresa A. Patterson Jr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-076623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Leeby M.D.

29c. License number

D0058904

29d. Date signed (Month, Day, Year)

4/30/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

319 S. Union Avenue Havre de Grace, MD 21078

31. Date filed (Month, Day, Year)

MAY 4 2004

32. Registrar's Signature

Kuan & Spauld

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

4/30/04 12:20AM

Packard, Margaret

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 15301

| | | | | | | | | |
|--|---|---|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margaret Lee Portzen | | | | 2. Date of Death Month May Day 2 Year 2004 | | 3. Time of Death 10:45A M | |
| | 4a. Facility Name (If not institution, give street and number) Civista Medical Center | | | | 4b. City, Town, or Location of Death La Plata | | 4c. County of Death Charles | |
| Funeral Director | 5. Social Security Number 217-28=8749 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 24, 1932 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State Maryland | | 10b. County Charles | | 10c. City, Town or Location White Plains | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 3735 Middletown Road | | | | 10f. Zip Code 20695 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | 16b. Kind of Business/Industry Paving Company | |
| | 17. Father's Name (First, Middle, Last) James Gibbons Hammett | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Blondell Potter | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Sandy Buchanan - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2102 Country Pines Ct., Waldorf, MD 20601 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peter's Ch. Cemetery | | Date 5-5-04 | | 20c. Location - City or Town, State Waldorf, MD | |
| | 21. Signature of Funeral Service Licensee Jack A. Wilson MO1246 | | | | 22. Name and Address of Facility Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Chronic obstructive pulmonary Disease Due to (or as a consequence of): and Cardiomypathy Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| Approximate Interval Between Onset and Death years years | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier B. Larry Jenkins | | | | 29c. License number D-33426 | | 29d. Date signed (Month, Day, Year) 5-3-04 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Larry Jenkins, MD 111 La Grange Avenue, La Plata, Maryland 20646 | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 04 2004 | | | | 32. Registrar's Signature [Signature] | | | | |

Margaret Lee Portzen
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No. 2004 15302

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

George Thornton Parezo

2. Date of Death
Month Day Year
April 25, 20043. Time of Death
10:00A M

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

579-48-4934

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth
(Month, Day, Year)

Nov. 20, 1934

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20119 Waterside Drive

10f. Zip Code

20874

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1952-195413. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Master Electrician

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

George E. Parezo

18. Mother's Name (First, Middle, Maiden Surname)

Jane Thornton

19a. Informant's Name/Relationship (Type, Print)

Molly M. Parezo/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20119 Waterside Drive, Germantown, Maryland 20874

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Montgomery
Crematorium, Inc.Date
April 27,
2004

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00803

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause or each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death
MINUTE

3 days

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE
CONGESTIVE HEART FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. D.

29c. License number

D46364

29d. Date signed (Month, Day, Year)

APRIL 25, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FELIX SOICOLSKY 11125 ROCKVILLE PIKE #205. ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15303

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Therese Philippe Pierre-Louis

2. Date of Death

April 25, 2004

3. Time of Death

6:44 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

099-48-5609

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Nov. 3, 1933

9. Birthplace (State or Foreign Country)

Haiti

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2109 Drexel Street

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Philippe

18. Mother's Name (First, Middle, Maiden Surname)

Viergelie Batichon

19a. Informant's Name/Relationship (Type, Print) - Husband

Max Etienne Pierre-Louis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2109 Drexel Street, Adelphi, Maryland 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Gate of Heaven
Cemetery

Date

May 1,
2004

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Bilateral Pneumonia
Due to (or as a consequence of):b. Loculated Pleural Effusions
Due to (or as a consequence of):c. Renal Failure
Due to (or as a consequence of):d. Diabetes MellitusApproximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D0056153

29d. Date signed (Month, Day, Year)

4/26/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kristie D. Nowak M.D. 1500 Forest Glen Road, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15304

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Elmer Plater | | 2. Date of Death Month Day Year April 24 2004 | | 3. Time of Death 6:15 PM | |
| 4a. Facility Name (If not institution, give street and number) Kensington Nursing & Rehab Center | | 4b. City, Town, or Location of Death Kensington | | 4c. County of Death Montgomery | |
| 5. Social Security Number 578-20-5087 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | 8. Date of Birth (Month, Day, Year) July 19, 1922 | 9. Birthplace (State or Foreign Country) Washington, DC | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Montgomery | 10c. City, Town or Location Silver Spring | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 2200 Evans Drive | | 10f. Zip Code 20902 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1943 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Afro-American | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver | | 16b. Kind of Business/Industry Transportation | |
| 17. Father's Name (First, Middle, Last) Jake Plater | | | 18. Mother's Name (First, Middle, Maiden Surname) Sadie Wheeler | | |
| 19a. Informant's Name/Relationship (Type, Print) Ahkeelah Karriem (daughter) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2200 Evans Drive, Silver Spring, MD 20902 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial | | 20c. Location - City or Town, State Landover, MD | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Washington, D.C. 20012 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure Severe Hypertension | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D 32332 | | 29d. Date signed (Month, Day, Year) April 27, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SK Gupta, M.D. 9801 Georgia Ave. Silver Spring, MD 20902 | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | 32. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15305

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Gloria Cristina Plaza-Fuentes

2. Date of Death

Month Day Year
April 25, 2004

3. Time of Death

4:25 a M

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

577-78-3599

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
May 23, 1945

9. Birthplace (State or Foreign Country)

Colombia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5225 Pooks Hill Road, #1307-S

10f. Zip Code

20814

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

4

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☒ Yes ☐ No Specify: Colombian

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Financial Management

17. Father's Name (First, Middle, Last)

Lazaro Plaza

18. Mother's Name (First, Middle, Maiden Surname)

Mery Fuentes

19a. Informant's Name/Relationship (Type, Print)

Amalia Plaza-Alvarez/ Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Calle 22-B #63 Int. 2, Apt. 401, Bogota, Colombia

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

April 27, 2004

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.

500 University Blvd. W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Arrest

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

19 Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Neutropenia

Due to (or as a consequence of):

Days

c. Colon Cancer

Due to (or as a consequence of):

Months

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Deena J. Shapiro M.D.

29c. License number

D35336

29d. Date signed (Month, Day, Year)

April 25, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deena J. Shapiro M.D. 10810 Connecticut Avenue, Kensington, MD 20895

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

Deena J. Shapiro

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

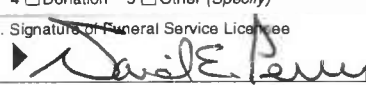
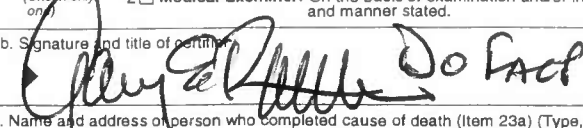

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15306

1- For State Registrar

| | | | | | | | | | | | |
|--|---|--|---|---|--|--|---|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margery S. Pollack | | | | 2. Date of Death Month Day Year April 24, 2004 | | | | 3. Time of Death 8:00 P M | | |
| | 4a. Facility Name (If not institution, give street and number) 7512 Holiday Terrace | | | | 4b. City, Town, or Location of Death Bethesda | | | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 578-32-8863 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 15, 1918 | | 9. Birthplace (State or Foreign Country) Minnesota | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | | 10b. County Montgomery | | | 10c. City, Town or Location Bethesda | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 7512 Holiday Terrace | | | | 10f. Zip Code 20817 | | | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | | 16b. Kind of Business/Industry Hospitality | | | |
| 17. Father's Name (First, Middle, Last) William Alphonso Savage | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Irene Ann Devitt | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ross Pollack/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1446 Amanda Park Lane, Charleston, SC 29412 | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. | | Date April 27, 2004 | | 20c. Location - City or Town, State Bethesda, Maryland | | | |
| 21. Signature of Funeral Service Licensee  MO0803 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aortic Stenosis, End Stage Due to (or as a consequence of): b. Rheumatic Valvular Heart Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| Approximate Interval Between Onset and Death | | | | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Degenerative Joint Disease Osteopenia | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  DO NOT | | | | 29c. License number H45839 | | | | 29d. Date signed (Month, Day, Year) May 26, 2004 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary E. Raffel, D.O. 5411 West Cedar Lane, #202A, Bethesda, Maryland 20814-1150 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND#23a(b) per MD5/5/04, BW, MCo Certificate of Death

Reg. No. 2004 15307

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,


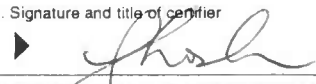

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last) Jacqueline F. Preston | | 2. Date of Death Month Day Year April 19 2004 | | 3. Time of Death 1:44 P M | |
| 4a. Facility Name (If not institution, give street and number) Suburban Hospital | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| 5. Social Security Number 153-20-6471 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | 8. Date of Birth (Month, Day, Year) Nov. 29, 1925 | | 9. Birthplace (State or Foreign Country) NY |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County Montgomery | 10c. City, Town or Location Rockville | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 5550 Tuckerman Lane | | 10f. Zip Code 20852 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) John F. Kenneally | | | 18. Mother's Name (First, Middle, Maiden Surname) Amelia A. Grantmayer | | |
| 19a. Informant's Name/Relationship (Type, Print) Kathleen Orr/ Daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9808 Montauk Avenue, Bethesda, MD 20817 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven | | 20c. Location - City or Town, State April 22 2004 Silver Spring | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Coronary Syndrome Due to (or as a consequence of): Type I b. Diabetes Mellitus Type II Due to (or as a consequence of): c. Congestive Heart Failure Due to (or as a consequence of): d. Hypoglycemia | | | | | Approximate Interval Between Onset and Death |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown |
| 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death Check only one Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D30132 | | 29d. Date signed (Month, Day, Year) April 21, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Rita Ghosh, M.D., 14804 Physicians Lane #221, Rockville, MD 20850 | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15308

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) David Raymond Price | | | | 2. Date of Death Month April Day 23 Year 2004 | | 3. Time of Death 9:40 A M | |
| 4a. Facility Name (If not institution, give street and number) Suburban Hospital | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| 5. Social Security Number 213-33-0701 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 24 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 11, 1979 | |
| 9. Birthplace (State or Foreign Country) Texas | | Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Bethesda | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 7120 Armat Dr. | | | | 10f. Zip Code 20817 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student | | 16b. Kind of Business/Industry | |
| 17. Father's Name (First, Middle, Last) Paul Price | | | | 18. Mother's Name (First, Middle, Maiden Surname) Janice Parker | | | |
| 19a. Informant's Name/Relationship (Type, Print) Paul Price/ Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7120 Armat Dr., Bethesda, MD 20817 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington | | Date April, 30 2004 | | 20c. Location - City or Town, State Laurel, MD | |
| 21. Signature of Funeral Service Licensee <i>M. C. Kelly</i> MO1296 | | | | 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, DC 20016 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Asphyxiation Due to (or as a consequence of): b. Depression Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) Apr. 23, 2004 | | 28b. Time of Injury 9:00 a.m. | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify) home | | 28d. Describe how injury occurred Hanging | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7120 Armat Dr., Bethesda, MD | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <i>Patricia Tomsko Nay, MD</i> | | | | 29c. License number D51916 | | 29d. Date signed (Month, Day, Year) Apr. 23, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Tomsko Nay, MD, 6121 Montrose Rd., Rockville, MD 20852 | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | | | 32. Registrar's Signature <i>Steve S. Sparks</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DAVID PRICE 4/23/04 0940

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15309

1- For State Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|---|---------------------------------------|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Beulah G. Ramsey | | | | 2. Date of Death Month April Day 23 Year 2004 | | | | 3. Time of Death 10:10 AM | |
| | 4a. Facility Name (If not institution, give street and number) Suburban Hospital | | | | 4b. City, Town, or Location of Death Bethesda | | | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 577-60-3693 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 100 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 9, 1903 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State D.C. | | 10b. County N/A | | 10c. City, Town or Location Washington | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number 1213 Crittenden Street, N.W. | | | | 10f. Zip Code 20011 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elevator Operator Supervisor | | | 16b. Kind of Business/Industry Federal Government | | |
| | 17. Father's Name (First, Middle, Last) Harry Gray | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Laura Hurd | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Sandra Caviness (Friend) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4706 9th Street, N.W., Washington, D.C. 20011 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Christ Reformed Congregation | | Date 4/29/04 | | 20c. Location - City or Town, State Middletown, MD | | | |
| | 21. Signature of Funeral Service Licensee Thomas H. Clyburn | | | | 22. Name and Address of Facility McGuire Funeral Service 7400 Georgia Ave. N.W., Washington, D.C. 20012 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE | | | | | | | | | |
| | 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number D 52767 | | 29d. Date signed (Month, Day, Year) 04/24/04 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. S. SETHI 50 W EDMONSTON DRIVE #303 ROCKVILLE MD 20852 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | 32. Registrar's Signature [Signature] | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15310

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Richard Charles Reardon | | 2. Date of Death Month Day Year April 22 2004 | | 3. Time of Death 10:28 A^M | |
| 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| 5. Social Security Number 314-07-4867 | 6. Sex <input type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | 8. Date of Birth (Month, Day, Year) July 12, 1919 | | 9. Birthplace (State or Foreign Country) IL |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County Montgomery | 10c. City, Town or Location Gaithersburg | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 333 Russell Avenue #507 | | 10f. Zip Code 20877 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Logistics Officer | | 16b. Kind of Business/Industry CIA | | | |
| 17. Father's Name (First, Middle, Last) Charles Walter Reardon | | | 18. Mother's Name (First, Middle, Maiden Surname) Eulala Vonee Estep | | |
| 19a. Informant's Name/Relationship (Type, Print) Randall P.R. Reardon/Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5740 Heatherwood Court, New Market, MD 21774 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington Cemetery | | 20c. Location - City or Town, State Arlington, Virginia | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death |
| a. Pneumonia Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input checked="" type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier  | | 29c. License number D58681 | | 29d. Date signed (Month, Day, Year) April 22, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jude Alexander, M.D., 9901 Medical Center Drive, Rockville, MD 20850 | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15311

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) ANWER JAHAN REHMAN 2. Date of Death Month Day Year April 26, 2004 3. Time of Death 1:30p M

Funeral Director

4a. Facility Name (If not institution, give street and number) Hebrew Home Of Greater Wash. 4b. City, Town, or Location of Death Rockville 4c. County of Death Montgomery

5. Social Security Number 452-51-3763 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 94 Yrs. 8. Date of Birth (Month, Day, Year) Oct. 29, 1909 9. Birthplace (State or Foreign Country) Pakistan

Usual Residence of Decedent 10a. State Maryland 10b. County Montgomery 10c. City, Town or Location Rockville 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 5901 Montrose Rd. #103 10f. Zip Code 20852 10g. Citizen of What Country? USA

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Asian 14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 16b. Kind of Business/Industry Home

17. Father's Name (First, Middle, Last) Fazal Husain 18. Mother's Name (First, Middle, Maiden Surname) Nazeer Begum

19a. Informant's Name/Relationship (Type, Print) Pari Rehman- Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5901 Montrose Rd, Rockville, Md. 20852

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Geo. Wash. Cem. 4-27-04 20c. Location - City or Town, State Adelphi, Md.

21. Signature of Funeral Service Licensee [Signature] 22. Name and Address of Facility Universal II Mortuary Inc. 411 Kennedy St, N.W., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE RENAL FAILURE Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier [Signature] 29c. License number 055258 29d. Date signed (Month, Day, Year) April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary B. Wilks, MD, 622 MONTROSE ROAD ROCKVILLE MARYLAND 20852

31. Date filed (Month, Day, Year) APR 28 2004 32. Registrar's Signature [Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No. 2004 15312

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wealthy Mae Reisinger

2. Date of Death

Month Day Year
April 24, 2004

3. Time of Death

6:05 P^M

4a. Facility Name (If not institution, give street and number)

Vantage House

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

578-42-0916

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 16, 1909

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5400 Vantage Point Road

10f. Zip Code

21044

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Levi Cathell

18. Mother's Name (First, Middle, Maiden Surname)

Annie Mae Dennis

19a. Informant's Name/Relationship (Type, Print)

Letitia R. Geiger / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3856 Philip Ludwell, Williamsburg, Virginia 23188

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

May 1, 2004

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

M01305

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Cherry Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Dementia - ALZHEIMER'S

Approximate Interval Between Onset and Death
years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pneumonia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

M 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-34868

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. D. Green

4055 Litter Point Parkway, Columbia, MD 21044

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15313

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Lee Layne Ricci

2. Date of Death

April 27, 2004

3. Time of Death

4:20 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

21010 Blunt Road

4b. City, Town, or Location of Death

Germantown

4c. County of Death

Montgomery

5. Social Security Number

578-12-7111

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 4, 1920

9. Birthplace (State or Foreign Country)

Lynchburg, VA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21010 Blunt Road

10f. Zip Code

20876

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Dept. of Commerce

17. Father's Name (First, Middle, Last)

Harry Arthur Layne

18. Mother's Name (First, Middle, Maiden Surname)

Della Mona Purcell

19a. Informant's Name/Relationship (Type, Print)

Roberta Ricci - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21010 Blunt Rd., Germantown, MD 20876

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Comfort

Date

April 29, 2004

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons
5130 Wisconsin Ave. NW Washington, DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myeloma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
3 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

022775

29d. Date signed (Month, Day, Year)

April 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Barr, M.D. 5454 Wisconsin Ave. NW #1345 Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15314

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Helen Mae Ridgley

2. Date of Death

April 23 2004

3. Time of Death

6:27 aM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral Director

5. Social Security Number

579-46-0085

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 2, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3000 Findley Road

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Deli Manager

16b. Kind of Business/Industry

Grocery Store

17. Father's Name (First, Middle, Last)

Edward Brian Grimes

18. Mother's Name (First, Middle, Maiden Surname)

Helen Marie Anderson

19a. Informant's Name/Relationship (Type, Print)

Sandra L. Bennett Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3000 Findley Road Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park 04/27/04 Rockville, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John E. Parker

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CAUSE PULMONARY EMBOLISM

Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Leo C. Rotello MD

29c. License number

52774

29d. Date signed (Month, Day, Year)

4/24/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEO C. ROTELLO MD, SUBURBAN HOSPITAL, BETHESDA MD 20814

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Barbara B. Sparks

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No.

2004 15315

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Francis Aloysius Rupp

2. Date of Death

April 26, 2004

3. Time of Death

9:39 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

11411 Blue Ridge Drive

4b. City, Town, or Location of Death

Beltsville

4c. County of Death

Prince George's

5. Social Security Number

578-03-6119

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 4, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11411 Blue Ridge Drive

10f. Zip Code

20705

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1940-4513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Cryptanalyst

16b. Kind of Business/Industry

National Security Agency

17. Father's Name (First, Middle, Last)

William Henry Rupp

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Gilmore

19a. Informant's Name/Relationship (Type, Print)

Evangeline W. Rupp/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11411 Blue Ridge Drive, Beltsville, MD 20705

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Gate of Heaven
Cemetery

Date

April 29,
2004

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Wilma L. B. J.

22. Name and Address of Facility

Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4-5 Years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Cardiomyopathy

Due to (or as a consequence of):

4-5 Years

c. Cardiac Arrhythmia

Due to (or as a consequence of):

4-5 Years

d. Hypertension

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
investigation
6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Sita Krishnamoorthy M.D.

29c. License number

D38139

29d. Date signed (Month, Day, Year)

April 28, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sita Krishnamoorthy M.D. 12201 Plum Orchard Dr., Silver Spring, MD 20904

Kaiser Permanente

State
Registrar

31. Date filed (Month, Day, Year)

APR 29 2004

32. Registrar's Signature

Sita Krishnamoorthy

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23c or 28a-f show
any injury or other traumatic event, this Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15316

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JACQUELINE ROUDIEZ

2. Date of Death

Month Day Year
APRIL 23 2004

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

301 SHIPPING CREEK DRIVE

4b. City, Town, or Location of Death

STEVENSVILLE

4c. County of Death

QUEEN ANNE'S

Funeral
Director

5. Social Security Number

136-58-0551

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 10, 1922

9. Birthplace (State or Foreign Country)

FRANCE

Usual Residence of Decedent

10a. State

MD

10b. County

QUEEN ANNE'S

10c. City, Town or Location

STEVENSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

301 SHIPPING CREEK DRIVE

10f. Zip Code

STEVENSVILLE

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

GEORGE STRICH

18. Mother's Name (First, Middle, Maiden Surname)

CECILE BERTHE FELICIER

19a. Informant's Name/Relationship (Type, Print)

FRANCIS ROUDIEZ/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 JEAN ROAD, STEVENSVILLE, MD 21666

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Date

04/24/2004

20c. Location - City or Town, State

STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

Thomas K. Helfenbein

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A.
106 SHAMROCK RD., CHESTER, MD 21619

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Depression
Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jamie Harms

29c. License number

071339

29d. Date signed (Month, Day, Year)

5/3/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMIE HARMS, MD 130 LOVE POINT ROAD, STEVENSVILLE, MD 21666

31. Date filed (Month, Day, Year)

MAY - 3 2004

32. Registrar's Signature

[Signature]

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15317

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MAYBELLE RIDENOUR

2. Date of Death

Month Day Year
APRIL 25 2004

3. Time of Death

16:19 PM

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

147-18-5507

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 12, 1923

9. Birthplace (State or Foreign Country)

Maine

Usual Residence of Decedent

10a. State

MD

10b. County

Talbot

10c. City, Town or Location

Trappe

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

29811 Bolingbroke Pt. Dr.

10f. Zip Code

21673

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Sumame)

Delores Berniere Parisiene

19a. Informant's Name/Relationship (Type, Print)

Paul Ridenour

son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3421 Cross Meadow Dr., Murfreesboro, TN 37130

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Woodlawn Memorial Park

Date

4/30/04

20c. Location - City or Town, State

Easton, MD

21. Signature of Funeral Service Licensee

Brian K. Butler

22. Name and Address of Facility

Thomas Funeral Home P.A.

700 Locust St., Cambridge, MD 21613

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):

MULTISYSTEM ORGAN FAILURE

b. Due to (or as a consequence of):

SEPTIC SHOCK

c. Due to (or as a consequence of):

CHRONIC IMMUNOSUPPRESSION

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 WEEKS

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DERMATOMYOSITIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cynthia Pena MD

29c. License number

AU 4176435, 14416

29d. Date signed (Month, Day, Year)

April 25, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYNTHIA PENA, MD 22 S. GREENE ST. BALTIMORE, MD

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

John K. Smith

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15318

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68768

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner
Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Ada May Stumpf | | | | 2. Date of Death Month May Day 5 Year 2004 | | 3. Time of Death 6:00 am | |
| 4a. Facility Name (If not institution, give street and number) Cumberland Nursing Center | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | |
| 5. Social Security Number 216-66-0584 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 90 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov 7, 1913 | 9. Birthplace (State or Foreign Country) PA |
| Usual Residence of Decedent | | | | | | | |
| 10a. State PA | | 10b. County Bedford | | 10c. City, Town or Location Bedford | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 365 Evitts Creek Road | | | | 10f. Zip Code 15522 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) Charles Lesh | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Lesh | | | |
| 19a. Informant's Name/Relationship (Type, Print) Wilma Ware daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 365 Evitts Creek Road Bedford PA 15522 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park | | Date 5/8/2004 | | 20c. Location - City or Town, State Cumberland MD | |
| 21. Signature of Funeral Service Licensee <i>James F Scarpelli</i> | | | | 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial infarction Due to (or as a consequence of): b. CAD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last COPD | | | | | | | Approximate Interval Between Onset and Death minutes |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <i>Peter Halmos MD</i> | | | | 29c. License number D04981 | | 29d. Date signed (Month, Day, Year) May 5, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER HALMOS 302 Schlegel Cumberland Md 21502 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 12 2004 | | | | 32. Registrar's Signature <i>John A. Smith</i> | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15319

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MURRAY SCHAEFER

2. Date of Death

Month Day Year
April 27, 2004

3. Time of Death

10:55 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

7841 Coddle Harbor Lane

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

5. Social Security Number

052-16-1529

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Jan. 24, 1923

9. Birthplace (State or Foreign Country)

New York, N.Y.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7841 Coddle Harbor Lane

10f. Zip Code

20854

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942 to 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Sales

17. Father's Name (First, Middle, Last)

Samuel Schaefer

18. Mother's Name (First, Middle, Maiden Surname)

Miriam Weinberg

19a. Informant's Name/Relationship (Type, Print)

Marc Schaefer/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10912 Lamplighter Lane, Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King David Memorial 04/30/2004

Date

20c. Location - City or Town, State

Falls Church, Virginia

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.
11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Normal Pressure Hydrocephalus

Chronic Obstructive Pulmonary Disease

Diabetes Mellitus, Ventricular Arrhythmia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Irving Mizus

29c. License number

D-26571

29d. Date signed (Month, Day, Year)

April 28, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Irving Mizus, M.D., 10215 Fernwood Road, Bethesda, Maryland 20817

State
Registrar

31. Date filed (Month, Day, Year)

APR 29 2004

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

MURRAY SCHAEFER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No. 2004 15320

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Katherine Scharff

2. Date of Death

Month Day Year
April 28, 2004

3. Time of Death

8:00 PM^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Nursing Center

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

202-01-7504

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 14, 1920

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17009 King James Way, #102

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Mark Daniel Willenbecher

18. Mother's Name (First, Middle, Maiden Surname)

Mary Senia Reppert

19a. Informant's Name/Relationship (Type, Print)

Darlene Mary Brown/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17009 King James Way, #101, Gaithersburg, MD 20877

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)
Montgomery
Crematorium Inc.

Date

May 1,
2004

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

[Signature] M00803

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Year

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Thrombocytopenia

Gastrointestinal Bleeding

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D28656

29d. Date signed (Month, Day, Year)

April 29, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ravi Passi, M.D. 15225 Shady Grove Road, #208, Rockville, Maryland 20850-3258

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15321

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL KEVIN SCHREIBER

2. Date of Death

Month Day Year
APR 26 2004

3. Time of Death

7:35 AM

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

172-48-2388

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 15, 1956

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

VA.

10b. County

NONE

10c. City, Town or Location

ALEXANDRIA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1213 W. BRADDOCK RD.

10f. Zip Code

22302

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1982-2004

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

U.S. MARINE

16b. Kind of Business/Industry

DEFENSE

17. Father's Name (First, Middle, Last)

PAUL C. SCHREIBER

18. Mother's Name (First, Middle, Maiden Surname)

ELLEN MURPHY

19a. Informant's Name/Relationship (Type, Print)

GRETCHEN SCHREIBER/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1213 W. BRADDOCK RD., ALEXANDRIA, VA. 22302

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON NAT'L. CEM. 6-9-2004

Date

20c. Location - City or Town, State

ARLINGTON, VA.

21. Signature of Funeral Service Licensee

A. N. Chambers

M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MESENTERIC ISCHEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Hans A. Brings MD

29c. License number

GFE58817 (CA)

29d. Date signed (Month, Day, Year)

4/27/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANS A. BRINGS CAPT MC USN

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

B Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15322

1- For
State
Registrar

| | | | | | | | | | | | |
|---|---|--|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Isaak Slezing | | | 2. Date of Death Month Day Year 4-27-04 | | | 3. Time of Death 12:05 P. M | | | | |
| | 4a. Facility Name (If not institution, give street and number) 4521 East-West Hgwy. | | | 4b. City, Town, or Location of Death Bethesda | | | 4c. County of Death Montgomery | | | | |
| Funeral Director | 5. Social Security Number 218-27-0868 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) 3-22-23 | | 9. Birthplace (State or Foreign Country) Ukraine | | |
| | 10a. State MD | | | 10b. County Montgomery | | | 10c. City, Town or Location Bethesda | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 4521 East-West Hgwy. | | | 10f. Zip Code 20814 | | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professor of Mathematics | | | 16b. Kind of Business/Industry Education | | | | | |
| 17. Father's Name (First, Middle, Last) Nison Slezing | | | 18. Mother's Name (First, Middle, Maiden Surname) Paulina Kanevesky | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Eleonora Slezing - Daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19147 Stedwick Dr. Montgomery Village, MD 20886 | | | | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crem. | | | Date 4-29-04 | | | 20c. Location - City or Town, State Brentwood, MD | | |
| 21. Signature of Funeral Service Licensee  | | | 22. Name and Address of Facility Hines-Rinaldi F. H. 11800 New Hampshire Ave. Silver Spring, MD 20904 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cholangiocarcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | Approximate Interval Between Onset and Death 1 1/2 yrs. | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | | 28b. Time of Injury M | | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | 28d. Describe how injury occurred | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier  | | | 29c. License number D22775 | | | 29d. Date signed (Month, Day, Year) 4-28-2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick G. Barr, M.D. 2101 Medical Park Dr. Suite 200, Silver Spring, MD 20902 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 29 2004 | | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15323

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louise O. Stewart

2. Date of Death

Month Day Year
April 26, 2004

3. Time of Death

8:00 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Andrus House

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

496-32-5983

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
January 25, 1903

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fairfax

10c. City, Town or Location

McLean

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1633 Evers Drive

10f. Zip Code

22101

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Fred Caster

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Grossniklaus

19a. Informant's Name/Relationship (Type, Print)

Fred W. Pickett (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1633 Evers Drive., McLean, Virginia 22101

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cremation Center

Date

4/27/04

20c. Location - City or Town, State

Chantilly, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Murphy Funeral Home, 1102 W. Broad St., Falls Church, Va.

22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Stroke
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Hypertension
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

0101047917

29d. Date signed (Month, Day, Year)

4-26-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTOPHER J. BARNETT MD

1515 Cham Bay Rd McLean Va 22101

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 must be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.




State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15324

1- For State Registrar

Physician /Medical Examiner
Funeral Director

| | | | | |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Kathleen A. Touchette | | 2. Date of Death Month April Day 29 Year 2004 | | 3. Time of Death 6:00 aM |
| 4a. Facility Name (If not institution, give street and number) 32 Club Lane | | 4b. City, Town, or Location of Death Earleville | | 4c. County of Death Cecil |
| 5. Social Security Number 221-28-3613 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 61 Yrs. | 8. Date of Birth (Month, Day, Year) October 13, 1942 | 9. Birthplace (State or Foreign Country) Delaware |
| Usual Residence of Decedent | | | | |
| 10a. State Maryland | 10b. County Cecil | 10c. City, Town or Location Earleville | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 10e. Street and Number 32 Club Lane | | 10f. Zip Code 21919 | | 10g. Citizen of What Country? United States |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Supervisor | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insurance | | 16b. Kind of Business/Industry Insurance | | |
| 17. Father's Name (First, Middle, Last) Charles Eben Alfree, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Helen Mary Smith | | |
| 19a. Informant's Name/Relationship (Type, Print) Gerald J. Touchette/Husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Club Lane, Earleville, Maryland 21919 | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glebe Cemetery | | 20c. Location - City or Town, State May 3, 2004 New Castle, Delaware |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colon Carcinoma Due to (or as a consequence of): a. Colon Carcinoma b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) M | | 28b. Time of Injury M |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier  | | 29c. License number H0035860 | | 29d. Date signed (Month, Day, Year) 4/29/04 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irving M. Berkowitz DO 8235 Ogletown Stanton Rd Newark DE 19713 | | | | |
| 31. Date filed (Month, Day, Year) APR 30 2004 | | 32. Registrar's Signature  | | |

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15325

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Stephen Trigonoplos

2. Date of Death

Month Day Year
May 1, 2004

3. Time of Death

10:30 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

8758 King George Court

4b. City, Town, or Location of Death

Pomfret

4c. County of Death

Charles

5. Social Security Number

214-32-3223

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 2, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Pomfret

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8758 King George Court

10f. Zip Code

20675

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1954-6213. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Director

16b. Kind of Business/Industry

Federal Railway
Administration

17. Father's Name (First, Middle, Last)

Constantine Augustus Trigonoplos

18. Mother's Name (First, Middle, Maiden Surname)

Della Florence Keller

19a. Informant's Name/Relationship (Type, Print)

Patrick S. Trigonoplos - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

802 Brookshade Pkwy, Alpharetta, GA 30004

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland Veterans' Cem. 5-7-04

Date

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

M00053

22. Name and Address of Facility

Huntt Funeral Home
P. O. Box 156, Waldorf, MD 2060423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Gun shot wound to the head
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☒ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)

05/01/2004

28b. Time of
Injury

10:30 AM

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Self-inflicted Gun shot
wound to head28e. Place of Injury. At home, farm, street, factory, office
building, etc. (Specify)

Residence

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

8758 King George Ct. Pomfret, MD

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Yahia M. Tagouri, MD

29c. License number

D-50883

29d. Date signed (Month, Day, Year)

May 3rd 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yahia M. Tagouri, MD, 25500 Point Lookout Road, Leonardtown, MD 20650

31. Date filed (Month, Day, Year)

MAY 04 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15326

1- For State Registrar

Physician / Medical Examiner
Funeral Director

| | | | | | |
|--|--|---|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last) EDWIN ROCKFORD THOMPSON, JR. | | 2. Date of Death Month Day Year APRIL 24, 2004 | | 3. Time of Death M 4:10P. | |
| 4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital | | 4b. City, Town, or Location of Death Laurel | | 4c. County of Death Prince George's | |
| 5. Social Security Number 579-24-8676 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jan. 30, 1928 |
| 9. Birthplace (State or Foreign Country) Washington, D.C. | | Usual Residence of Decedent | | | |
| 10a. State Maryland | 10b. County Prince George's | 10c. City, Town or Location Beltsville | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 4508 Tonquil Place | | 10f. Zip Code 20705 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer | | 16b. Kind of Business/Industry Johns Hopkins Applied Physics Lab | | | |
| 17. Father's Name (First, Middle, Last) Edwin R. Thompson, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Pearl | | | |
| 19a. Informant's Name/Relationship (Type, Print) Michael E. Thompson -son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4504 Tonquil Place Beltsville, Maryland 20705 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Location - City or Town, State 4/26/2004 Alexandria, Virginia | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Donald V. Borwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Ischemic Colitis Due to (or as a consequence of): c. Peritonitis Due to (or as a consequence of): d. Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GI Bleeding; Renal Failure; Thrombocytopenia | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> Physician Attending | | 29c. License number D42580 | | 29d. Date signed (Month, Day, Year) April 25, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.S. Aujla, M.D. 5632 Annapolis Road, #13 Bladensburg, Maryland 20710 | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

To Be Completed by Funeral Director

Physician / Medical Examiner

To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #5 per attorney 6835 7/13/04 LLS
 State of Maryland / Department of Health and Mental Hygiene
 Certificate of Death
 Reg. No. 2004 15327

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) MELVIN DONALD THOMPSON | | 2. Date of Death Month Day Year April 22, 2004 | | 3. Time of Death 11:30 A^M | |
| 4a. Facility Name (If not institution, give street and number) 11335 Halethorpe Terrace | | 4b. City, Town, or Location of Death Germantown | | 4c. County of Death Montgomery | |
| 5. Social Security Number 309-28-5284 309-28-5284 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | |
| 8. Date of Birth (Month, Day, Year) Jan. 4, 1930 | | 9. Birthplace (State or Foreign Country) Michigan | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Md. | | 10b. County Montgomery | | 10c. City, Town or Location Germantown | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 11335 Halethorpe Terrace | | 10f. Zip Code 20876 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Regional Sales Manager | | 16b. Kind of Business/Industry Seed Company | |
| 17. Father's Name (First, Middle, Last) Melvin Thompson | | 18. Mother's Name (First, Middle, Maiden Surname) Essie Pettit | | | |
| 19a. Informant's Name/Relationship (Type, Print) Eva Krebs (Companion) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11335 Halethorpe Terrace Germantown, Md. 20876 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) All Souls Cemetery | | 20c. Location - City or Town, State April 27, 2004 Germantown, Md. | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death Years | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D 20148 | | 29d. Date signed (Month, Day, Year) April 23, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Steven Dolinsky M.D. 911 Russell Ave. Gaithersburg, Md. 20877 | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15328

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

SARA JANE WESTROD

2. Date of Death

May 2 2004

3. Time of Death

1430 M

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

222-24-4489

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
9-5-1939

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Delaware

10b. County

New Castle

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4820 Summit Bridge Rd.

10f. Zip Code

19709

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Food Store Worker

16b. Kind of Business/Industry

Supermarket

17. Father's Name (First, Middle, Last)

Arlington Lloyd

18. Mother's Name (First, Middle, Maiden Surname)

Anna Whiteoak

19a. Informant's Name/Relationship (Type, Print)

Robert J. Westrod

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4820 Summit Bridge Rd., Middletown, DE. 19709

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Odd Fellows Cemetery 5-7-04 Smyrna, DE.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANIELS & HUTCHISON

212 N. Broad Street, Middletown, DE. 19709

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Martha Hosford

29c. License number

D35653

29d. Date signed (Month, Day, Year)

05-03-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martha Hosford - Skopet, M.D. 111 W. High St., #104, Elkton, MD 21922

31. Date filed (Month, Day, Year)

MAY 4 2004

32. Registrar's Signature

Lisa S. Spivey

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15329

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELDON DAVID WAGNER

2. Date of Death

Month Day Year
APRIL 11, 2004

3. Time of Death

6:10 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2551 BALTIMORE BLVD. # 58

4b. City, Town, or Location of Death

FINKSBURG

4c. County of Death

CARROLL

5. Social Security Number

214-22-7167

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
9/3/1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

CARROLL

10c. City, Town or Location

FINKSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2551 BALTIMORE BLVD. # 58

10f. Zip Code

21048

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 1945
If Yes, Give Year or Dates: 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

AUTOMOBILE

17. Father's Name (First, Middle, Last)

CHARLES A. WAGNER

18. Mother's Name (First, Middle, Maiden Surname)

EVELYN GOBRIGHT

19a. Informant's Name/Relationship (Type, Print)

DORIS WAGNER - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21048
2551 BALTIMORE BLVD. # 58, FINKSBURG, MD.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ALL COUNTY CREMATION 4/12/04 SYKESVILLE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility FLETCHER FUNERAL HOME

254 T. MAIN ST., WESTMINSTER, MD. 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

7 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cerebrovascular accident

inferior myocardial infarction

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier
Thomas K. Galvin III

29c. License number

D31660

29d. Date signed (Month, Day, Year)

04/12/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS K. GALVIN III 291 STONER AVENUE WESTMINSTER, MARYLAND 21157

31. Date filed (Month, Day, Year)

APR 13 2004

32. Registrar's Signature

Brenda H. Spivey

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15330

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

| | | | | | | | | |
|---|---|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Hwa-Chuan Lu Wang | | | | 2. Date of Death Month April Day 24 , Year 2004 | | 3. Time of Death 3:00 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) 18101 Hayloft Drive | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 023-58-9411 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 20, 1925 | |
| | 9. Birthplace (State or Foreign Country) China | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 18101 Hayloft Drive | | 10f. Zip Code 20855 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Asian | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | 16b. Kind of Business/Industry Jr. High School | | | |
| | 17. Father's Name (First, Middle, Last) Hsueh-Wai Lu | | | | 18. Mother's Name (First, Middle, Maiden Surname) Chen-Shih Lu | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Chin-Yuan Derek Wang/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18101 Hayloft Drive, Rockville, Maryland 20855 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. Location - City or Town, State 4/26/2004 Silver Spring, MD. | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular Accident | | | | Approximate Interval Between Onset and Death 8 years | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypercholesterolemia | | | | | | | |
| | IF FEMALE 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month _____ Day _____ Year _____ | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypercholesterolemia | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D34567 | | 29d. Date signed (Month, Day, Year) Apr 24, 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Vietn Chiang, MD 9907 Medical Center Dr. Suite 320, Rockville MD 20850 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- Unpend Item #23a, 27, 28a-f per me G832 6/15/04 tas

Certificate of Death

Reg. No.

2004 15331

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Robert Lee Williams, Jr.

2. Date of Death

Month Day Year
APRIL 17, 2004

3. Time of Death

2314 P M

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

5. Social Security Number

318-50-0490

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
2-13-55

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

D.C.

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

753 Quebec Place, N.W.

10f. Zip Code

20010

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Construction

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Robert Lee Williams, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ruby Ann Montgomery

19a. Informant's Name/Relationship (Type, Print)

Diane Richardson/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5127 Hanna Pl. SE D.C. 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Vernon Mem Garden 5/1/04 Mt. Vernon, Ill.

21. Signature of Funeral Service Licensee

James E. Williams

22. Name and Address of Facility

The House of Williams
814 Upshur Street, N.W.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Multiple Injuries

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

- a. Due to (or as a consequence of):
- b. Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?
(Check only one)☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

4/17/04

28b. Time of Injury

10:23 P

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject was pedestrian struck by vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

40th Street E
Capitol St., Washington, DC

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. R. Hogan

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

APRIL 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. R. HOGAN

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

James B. Sparks

State Registrar

Baltimore, Maryland 21215-0036

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Items 24a, 25, 26, 27, 29a per Dr. 6831.05/23/04bb

2004 15332

Reg. No.

| | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles R Wagner | | | | 2. Date of Death Month Day Year Apr. 13, 2004 | | 3. Time of Death 10:20pm | | |
| | 4a. Facility Name (If not institution, give street and number) Devlin Manor Nursing Home | | | | 4b. City, Town, or Location of Death | | 4c. County of Death | | |
| Funeral Director | 5. Social Security Number 213-22-3269 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) Jun 9, 1926 | | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County Allegany | | 10c. City, Town or Location Cumberland | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 12D Wempe Drive | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry Railroad | | 17. Father's Name (First, Middle, Last) Fred E. Wagner | | 18. Mother's Name (First, Middle, Maiden Surname) Alice Beryl (Ganoe) Wagner | |
| 19a. Informant's Name/Relationship (Type, Print) Bettie Wagner wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3209 Bethesda Drive Waldorf MD 20601 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park | | 20c. Location - City or Town, State 4/16/2004 Cumberland MD | |
| 21. Signature of Funeral Service Licensee <i>James J. Scarpelli</i> | | 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 108 Virginia Avenue, Cumberland, MD 21502 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Rheumatoid Arthritis, Cerebrovascular Accident, Coronary Artery Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Approximate Interval Between Onset and Death days | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rheumatoid Arthritis, Cerebrovascular Accident, Coronary Artery Disease | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Beverly Calkins M.D.</i> | | 29c. License number D54411 | | 29d. Date signed (Month, Day, Year) APR 14, 2004 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beverly Calkins M.D. 500 Memorial Ave Ste 105 Cumberland MD 21502 | | 31. Date filed (Month, Day, Year) MAY 12 2004 | | 32. Registrar's Signature <i>Beverly Calkins</i> | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Register **AMEND ITEM #8 PER FH G831 5/14/04 JH** Certificate of DeathReg. No. **2004 15333**Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HERENIA M. WALDHAUSER

2. Date of Death

Month Day Year
APRIL 30 2004

3. Time of Death

0335 M

4a. Facility Name (If not institution, give street and number)

CORSICA HILLS NURSING HOME

4b. City, Town, or Location of Death

CENTREVILLE

4c. County of Death

QUEEN ANNE'SFuneral
Director

5. Social Security Number

215-09-1292

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
FEB. 25, 1910

Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

QUEEN ANNE'S

10c. City, Town or Location

CENTREVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

205 ARMSTRONG AVENUE

10f. Zip Code

21617

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: **WHITE**

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TAILOR

16b. Kind of Business/Industry

CLOTHING

17. Father's Name (First, Middle, Last)

KILLIAN WALDHAUSER

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE MAY BORGMANN

19a. Informant's Name/Relationship (Type, Print)

ANNA MAY ELLINGER / NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

200 TERRAPIN GROVE, STEVENSVILLE, MD 21666

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Date

5/06/2004

20c. Location - City or Town, State

STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A.**106 SHAMROCK ROAD, CHESTER, MD 21619**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D32036

29d. Date signed (Month, Day, Year)

4/30/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary J. Sprague 2108 D. Donahoe Drive Charles. MD 21619State
Registrar

31. Date filed (Month, Day, Year)

MAY - 3 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15334

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alta Marie Zembower

2. Date of Death

May 1, 2004

3. Time of Death

8:45 am M

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

212-12-8208

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Feb 9, 1909

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

411 Columbia Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas Roomsburg

18. Mother's Name (First, Middle, Maiden Surname)

Amy Belle (Combs) Roomsburg

19a. Informant's Name/Relationship (Type, Print)

Jack McNeill son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6705 Lehigh Avenue Harrisburg PA 17104

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

5/4/2004

20c. Location - City or Town, State

Cumberland MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Scarpelli Funeral Home, PA
108 Virginia Avenue, Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

BOWEL INFARCTION

Approximate Interval Between Onset and Death
24 hrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

THROMBOEMBOLIC EVENT

12 hrs.

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEART BLOCK

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

M 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

053152

29d. Date signed (Month, Day, Year)

5-5-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Stasko, MD 924 Seton Drive, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

MAY 12 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

unpend item #23a, Part II, 27, PER ME, G832, 6/24/04
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15335

1- For State Registrar **AMEND ITEM #1 PER ME G833 7/20/04**

Reg. No.

| | | | | | | | |
|---|--|--|--|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jean A. Atkinson JEAN E. ATKINSON | | | 2. Date of Death Month MAY Day 12 Year 2004 | | 3. Time of Death 14:50 M | |
| | 4a. Facility Name (If not institution, give street and number) UNIVERSITY HOSPITAL | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 194 24 0937 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 73 Yrs. | 8. Date of Birth (Month, Day, Year) 9/15/1930 | | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Rosedale 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 10e. Street and Number 1508 Cavel Rd | | | 10f. Zip Code 21237 | | 10g. Citizen of What Country? USA | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) (UNK) Montgomery | | | 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Wynn | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Troy Atkinson SON | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5629 Leiden Road Baltimore, MD. 21206 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 5/14/2004 | | 20c. Location - City or Town, State Catonsville MD |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Myocardial Necrosis complicating dialysis procedure for end stage renal disease | | | Approximate Interval Between Onset and Death | | | | |
| 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 24b. Were any findings available prior to death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier | | | | |
| 29c. License number O C M E | | | 29d. Date signed (Month, Day, Year) MAY 13, 2004 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | 31. Date filed (Month, Day, Year) MAY 13 2004 | | | | |
| 32. Registrar's Signature | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Register Amend item 11 per inf g835 9- Certificate of Death

Reg. No.

2004 15336

| | | | | | | | | |
|---|---|--|--|---|---|-----------------------------------|---|--|
| Physician / Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dora Mae Brown | | | 2. Date of Death Month May Day 10 Year 2004 | | 3. Time of Death 0643AM | | |
| | 4a. Facility Name (If not institution, give street and number) Good Samaritan Hosp. | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | | |
| Funeral Director | 5. Social Security Number 217-56-7528 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 53 Yrs. | | 8. Date of Birth (Month, Day, Year) 8-28-50 | |
| | 9. Birthplace (State or Foreign Country) N.C. | | 10a. State Md. | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 4003 White Ave. Apt. 3-B | | 10f. Zip Code 21206 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) 12th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Private Duty Nursing | | 16b. Kind of Business/Industry Varies | | 17. Father's Name (First, Middle, Last) James Otis Coppage | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Arlene Coppage | | 19a. Informant's Name/Relationship (Type, Print) Rhonda Chase Brown Daug-in-law | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3507 Royston Ave., Baltimore, Md. 21206 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Pk. | | 20c. Location - City or Town, State Dundalk, Md. | | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Asthma Exacerbation Due to (or as a consequence of): Tobacco Abuse Due to (or as a consequence of): | | 23b. If female, Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| | 29b. Signature and title of certifier Leisman - Internal Medicine | | 29c. License number H0059388 | | 29d. Date signed (Month, Day, Year) 5-11-04 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blvd., Russell Morgan Building Suite 500, Baltimore MD 21239 | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature | | 33. Registrar's Name Sparks | | 34. Registrar's Title Registrar | |

ck 5-21-04
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Faxed to M.E.
Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 15337

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JEAN M. BEALL

2. Date of Death

Month

Day

Year

MAY 4 2004

3. Time of Death

0930

Funeral
Director

4a. Facility Name (If not institution, give street and number)

120 5th Avenue, S.E.

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

AA

5. Social Security Number

217-56-3220

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

09/22/1949

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

120-5th Ave.

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Customer Service Representative

16b. Kind of Business/Industry

Food & Trucking

17. Father's Name (First, Middle, Last)

Ardell Anderson

18. Mother's Name (First, Middle, Maiden Surname)

Lois Erie

19a. Informant's Name/Relationship (Type, Print)

Steven Joseph Beall, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7916 Gough Street, Baltimore, Maryland 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mark's Cemetery

Date

05/07/2004

20c. Location - City or Town, State

Highland, Maryland

21. Signature of Funeral Service Licensee

Kenya Stewart

22. Name and Address of Facility

Fleck Funeral Home, Inc.
7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William P. Jones, MD

29c. License number

D06054

29d. Date signed (Month, Day, Year)

5/5/4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 695 America 21035

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

Kenya Stewart

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 15338

| | | | | | | | | | | |
|---|--|--|--|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Frank Boltz | | | | 2. Date of Death Month 5 Day 10 Year 2004 | | | | 3. Time of Death 2:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE Hospital | | | | 4b. City, Town, or Location of Death Rose Dale | | | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 097-16-0315 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 17, 1923 | | 9. Birthplace (State or Foreign Country) New York | |
| | 10a. State Maryland | | | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 5330 Castle Stone Drive | | | | 10f. Zip Code 21237 | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Artist | | | | 16b. Kind of Business/Industry Self-Employed Artist | | | | 17. Father's Name (First, Middle, Last) John Boltz | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Schelmeyer | | | | 19a. Informant's Name/Relationship (Type, Print) Mrs. Karen Myers (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5330 Castle Stone Drive, Baltimore, MD 21237 | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory | | | | 20c. Location - City or Town, State Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee Jill S. Beglanis | | | | 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | |
| | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9. Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | | | 23d. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypoxemia HTN, Chronic Pain Peripheral Vascular Disease | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| State Registrar | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier L. Faraz | | | | 29c. License number RES 0000 | |
| | 29d. Date signed (Month, Day, Year) 5-10-2004 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SABINA FARAZ 9000 FRANKLIN SQUARE DR. BALTIMORE Md. 21237 | | | | 31. Date filed (Month, Day, Year) MAY 13 2004 | |
| | 32. Registrar's Signature [Signature] | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15339

1- For State Registrar Amend & Unpend Item #1,23a,27,28,29 of Death Certificate of Death #832 6/2/04

| | | | | | | | | | | |
|---|---|--|---|---|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EARL WILLIAM BRAUN | | | 2. Date of Death Month Day Year May 6, 2004 | | | 3. Time of Death 0509 A M | | | |
| | 4a. Facility Name (If not institution, give street and number) 819 South Oldham Street | | | 4b. City, Town, or Location of Death Baltimore | | | 4c. County of Death | | | |
| Funeral Director | 5. Social Security Number 219-90-2804 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 27 Yrs. | | 8. Date of Birth Month Day Year JAN. 24, 1977 | | 9. Birthplace (State or Foreign Country) MD. | |
| | 10a. State MD. | | | 10b. County N/A | | | 10c. City, Town or Location BALTIMORE | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| To Be Completed by Funeral Director | 10e. Street and Number 819 OLDHAM STREET | | | 10f. Zip Code 21224 | | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINE OPERATOR | | | 16b. Kind of Business/Industry COMMERICAL CORRUGATED | | | |
| | 17. Father's Name (First, Middle, Last) EARL FRANCES BRAUN | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY CREED | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) MARY KOEHLER/MOTHER | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 FOLCROFT STREET, BALTIMORE, MARYLAND 21224 | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE/WASHINGTON | | | 20c. Location - City or Town, State LAUREL, MARYLAND | | 20d. Date 5/11/04 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Narcotic Intoxication Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | Approximate Interval Between Onset and Death | | | | | | |
| To Be Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | 23d. Date of delivery Month Day Year | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) At Scene | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) Found 5/6/04 | | 28b. Time of Injury (Month, Day Year) Found 5:09 A M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Unknown |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) May 6, 2004 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICIA ARONICA-BELLAK 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year) MAY 13 2004 | | | 32. Registrar's Signature | | | | | | |
| | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **2004 15340**
Certificate of Death

1- For State Registrar

Reg. No.

| | | | | | | | | | | |
|--|---|---|--|---|---|---|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Wade Leroy Cincibus | | | | 2. Date of Death Month May Day 12 Year 2004 | | | | 3. Time of Death 0230 A M | |
| | 4a. Facility Name (If not institution, give street and number) 358 Leeanne Road | | | | 4b. City, Town, or Location of Death Rosedale | | | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 217 24 9487 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) 05/31/1928 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Essex | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 358 Leeanne Road | | | | 10f. Zip Code 21221 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Highway Design | | 16b. Kind of Business/Industry State Highway Administ. | | | | |
| 17. Father's Name (First, Middle, Last) Anton Cincibus | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Harris | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Theresa Audrey Cincibus WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 358 Leeanne Road Essex Maryland 21221 | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 5-13-2004 | | 20c. Location - City or Town, State Catonsville MD | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Gvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death 10 years |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) | | | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death Check one Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | 29c. License number D18467 | | 29d. Date signed (Month, Day, Year) May 12, 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip M. Litallo, MD 6 Trimble Hill Ct, Lutherville, Maryland 21093 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | | | 32. Registrar's Signature | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15341

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Minnie Ethel Dorsett | | | | 2. Date of Death Month Day Year May 11, 2004 | | 3. Time of Death 5:40am M | |
| | 4a. Facility Name (If not institution, give street and number) 12105 Frederick Road | | | | 4b. City, Town, or Location of Death Marriottsville | | 4c. County of Death Howard County | |
| Funeral Director | 5. Social Security Number 579-34-0577 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 98 98 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 29, 1905 | |
| | 9. Birthplace (State or Foreign Country) NC | | 10a. State Md | | 10b. County Howard | | 10c. City, Town or Location Marriottsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 12105 Old Frederick Rd. | | 10f. Zip Code 21104 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | | | 16b. Kind of Business/Industry domestic | | 17. Father's Name (First, Middle, Last) Charlie Wilson | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Virginia Harrison | | | | 19a. Informant's Name/Relationship (Type, Print) Wanda Souder (daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1275 Guilford Rd. Eldersburg, Md 21784 | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation | | 20c. Location - City or Town, State Sykesville, MD | | 21. Signature of Funeral Service Licensee Blair A. Haight | |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility HATCHER FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiomyopathy | | Approximate Interval Between Onset and Death 4 weeks | |
| | 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year) M | | | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Abedia Ali Khan M.D. | | 29c. License number D43323 | |
| | 29d. Date signed (Month, Day, Year) MAY 11, 2004 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABEDIA ALI KHAN 10820 Hickory Ridge Road, Columbia MD 21044 | | 31. Date filed (Month, Day, Year) MAY 13, 2004 | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature B. Sparks | | | | 33. State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036 | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
 Amend Item #5 per G. Sparks 8/12/04 tas
 Certificate of Death

2004 15342

1- For State Registrar

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Clifton DeGraffinried Jr | | | | 2. Date of Death Month Day Year May 3, 2004 | | 3. Time of Death 10:02 PM | |
| | 4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death ALLEGANY | |
| Funeral Director | 5. Social Security Number 214-68-4469 216-68-4469 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 46 Yrs. | 8. Date of Birth (Month, Day, Year) 06 14 57 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County Allegany | |
| 10c. City, Town or Location Cumberland | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 13800 McMillian Highway | | | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) na | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator | | 16b. Kind of Business/Industry Machine Company | | |
| 17. Father's Name (First, Middle, Last) Clifton DeGraffinried | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marion Springfield | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mother Marion DeGraffinried | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2924 Forest Glen Road, Baltimore, Md 21216 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery | | 20c. Date 5/15/04 | | 20d. Location - City or Town, State Baltimore, Md | | |
| 21. Signature of Funeral Service Licensee <i>Thynette K. Jones</i> | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End stage Hepatic failure Due to (or as a consequence of): b. metabolic encephalopathy Due to (or as a consequence of): c. Hepatitis C Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 days 2 days 10 years | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypokalemia - Dehydration | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number 00 8377 | | 29d. Date signed (Month, Day, Year) May 4, 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Uriel Velandia 902 Seton Drive Cumberland, Md 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Amend Items 10c, 11 per 1A, 0331, 05/15/04

State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15343

Irvin Dubin
04-3123

AKG

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

IRVIN

DUBIN

2. Date of Death
Month Day Year
May 8, 2004

3. Time of Death
12:50 P^M

4a. Facility Name (If not institution, give street and number)

3211 Clarks Lane #315

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

212-20-7316

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

8. Date of Birth (Month, Day, Year)

02/25/1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

3211 CLARKS LANE #315 Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3211 CLARKS LANE #315

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

Divorced

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

COMMERICAL GLASS

17. Father's Name (First, Middle, Last)

ISRAEL

DUBIN

SOPHIE

GINSBERG

19a. Informant's Name/Relationship (Type, Print)

STEPHEN DUBIN / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 WESTDALE COURT TIMONIUM, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD VETERANS CEMETERY

Date

05/12/2004

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

Robert H. Leuninger

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD PIKESVILLE MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Mixed drug and alcohol intoxication

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) At scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)
found 5/8/04

28b. Time of Injury
unknown

28c. Injury at Work?
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred
subject ingested drugs and alcohol

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
home

28f. Location (Street and Number or Rural Route Number, City or Town, State)
3211 Clarks Lane, Baltimore, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Allen Weir

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 9, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Allen Weir, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 13, 2004

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15344

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Herbert L. Elliott | | | | 2. Date of Death Month 05 / Day 11 / Year 2004 | | 3. Time of Death 11:00pm | |
| | 4a. Facility Name (If not institution, give street and number) 1423 East Clement Street | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 214-01-0720 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth (Month, Day, Year) December 17, 1914 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore City | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1423 East Clement Street | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Longshoreman | | 16b. Kind of Business/Industry Shipping | | | | |
| 17. Father's Name (First, Middle, Last) Charles A. Elliott | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie G. Nun | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Holden J. Hodges, Jr. /Grandchild | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7613 Beaver Road, Glen Burnie MD 21060 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cem. | | Date May 14, 2004 | | 20c. Location - City or Town, State Baltimore Maryland | | |
| 21. Signature of Funeral Service Licentiate Victor P. Doda, Jr. | | 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave., Baltimore MD 21230 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ADENOCARCINOMA OF LUNGE | | 23b. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23c. Date of delivery Month Day Year | | 23d. Date of delivery Month Day Year | | |
| 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | |
| 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Afroze Muneer MD | | 29c. License number DUS105 | | |
| 29d. Date signed (Month, Day, Year) 5/12/04 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AFROZE MUNEER 901 E. FORT AVE MD 21230 | | 31. Date filed (Month, Day, Year) MAY 13-2004 | | 32. Registrar's Signature Sparks | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15345

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Dr. Theodore E. Evans | | | | 2. Date of Death Month MAY Day 7 Year 2004 | | 3. Time of Death 1800PM | |
| | 4a. Facility Name (If not institution, give street and number) Stella Maris at Mercy | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 215-28-0393 | | 6. Sex 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) Mar. 17, 1929 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Nottingham | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 4012 Kahlston Road | | 10f. Zip Code 21236 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physician | | 16b. Kind of Business/Industry Self-Employed Physician | | | |
| | 17. Father's Name (First, Middle, Last) Henry Edward Evans | | | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine Huebler | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mr. Todd Evans (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Midcrest Ct., Towson, MD 21286 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Mausoleum | | 20c. Location - City or Town, State 5/11/2004 Parkville, Maryland | | 20d. Date | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Brian A. Wheeler | | | | 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. prostate cancer | | | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) | | | |
| | 23d. Date of delivery Month Day Year | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Dr. Theodore E. Evans | | 29c. License number D40854 | |
| | 29d. Date signed (Month, Day, Year) 5/7/2004 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Riseberg 301 St Paul Pl Baltimore 21202 | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) MAY 13 2004 | | | | 32. Registrar's Signature [Signature] | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15346

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William B. Fitzpatrick

2. Date of Death

May

Day

11

Year

2004

3. Time of Death

1:20 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

8912 Mavis Ave.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

217-05-9999

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 20, 1918

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8912 Mavis Ave.

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Master Chief Petty Officer

16b. Kind of Business/Industry

U.S. Navy

17. Father's Name (First, Middle, Last)

Bernard F. Fitzpatrick

18. Mother's Name (First, Middle, Maiden Surname)

Della Peddicord

19a. Informant's Name/Relationship (Type, Print)

Colleen Iwanowski/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2703 Pemberton Ridge, Baldwin, Md. 21013

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bayview Crematory

Date

May 15, 2004

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

J. S. Baglanis

22. Name and Address of Facility

Schimunek Funeral Homes
9705 Belair Rd., Baltimore, Md. 2123623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Dementia

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an
autopsy
performed?
☐ Yes ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No26. Place of Death (Check only one)
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. A. R. Rasmussen

29c. License number

D36846

29d. Date signed (Month, Day, Year)

MAY 12, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERNARD H. RAUTZ M.D. 5629 LOMB CORNER ROAD WHITE HALL MD 21161

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

Bernard S. Rasmussen

State
Registrar

Fitzpatrick

Baltimore, Maryland 21215-0036

William

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15347

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Morris Gould

2. Date of Death

Month Day Year
MAY 11, 2004

3. Time of Death

1:15p M

4a. Facility Name (If not institution, give street and number)

1413 Tarragon Court

4b. City, Town, or Location of Death

Belcamp

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

119-07-5061

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG 4, 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Belcamp

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1413 Tarragon Court

10f. Zip Code

21017

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Credit Union

17. Father's Name (First, Middle, Last)

Samuel Gould

18. Mother's Name (First, Middle, Maiden Surname)

Reba

UNK.

19a. Informant's Name/Relationship (Type, Print)

Shirley J. Bouchet/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1413 Tarragon Court Belcamp, MD 21017

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

5-12-04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility

Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

chronic obstructive pulmonary Disease 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

S. Ragunani, MD

29c. License number

D-53720

29d. Date signed (Month, Day, Year)

05/11/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Ragunani MD, 602. S. E. Wood Rd, #106, Belair, MD 21014

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

Benjamin S. Spahr

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15348

1- State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

A

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GERALD GOLDMAN | | 2. Date of Death Month MAY Day 9 Year 2004 | | 3. Time of Death 12:20 A M |
| | 4a. Facility Name (If not institution, give street and number) FUTURE CARE CHERRYWOOD | | 4b. City, Town, or Location of Death REISTERSTOWN | | 4c. County of Death BALTIMORE |
| Funeral Director | 5. Social Security Number 220-74-5941 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | 8. Date of Birth (Month, Day, Year) JUNE 29, 1926 | |
| | 9. Birthplace (State or Foreign Country) MD | | Usual Residence of Decedent | | |
| 10a. State MD | | 10b. County BALTIMORE | 10c. City, Town or Location REISTERSTOWN | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 12020 REISTERSTOWN ROAD | | 10f. Zip Code 21136 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) NONE | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NONE | |
| 16b. Kind of Business/Industry NONE | | 17. Father's Name (First, Middle, Last) LOUIS GOLDMAN | | 18. Mother's Name (First, Middle, Maiden Surname) LEAH WEINBERG | |
| 19a. Informant's Name/Relationship (Type, Print) ELAINE SALGANIK / SISTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 HIGHSTEPPER COURT #303 - BALTIMORE, MD 21208 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ANSHE EMUNAH (AITZ CHAIM) | | 20c. Location - City or Town, State 5/11/04 BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular Disease | | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | |
| 23d. Date of delivery Month Day Year | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier | | 29c. License number 052882 | | 29d. Date signed (Month, Day, Year) 5/11/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L. Moss 117 Business Center Drive Reisterstown, MD 21136 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Items 25, 26, 29a, 29d, 30 per Dr. 4831-05/13/04dbb

Certificate of Death

Reg. No.

2004 15349

| | | | | | |
|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Frances C. Green | | 2. Date of Death Month April Day 13 Year 2004 | | 3. Time of Death 5:38 AM M |
| | 4a. Facility Name (If not institution, give street and number) Suburban Hospital | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery |
| Funeral Director | 5. Social Security Number 258-28-3731 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Mar 27, 1917 | | 9. Birthplace (State or Foreign Country) Georgia | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State MD | | 10b. County Montgomery |
| | 10c. City, Town or Location Bethesda | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 5215 W. Cedar Lane | | 10f. Zip Code 20814 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) school teacher | | 16b. Kind of Business/Industry education | | |
| | 17. Father's Name (First, Middle, Last) Frederick Cowan | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth Maddox | | |
| | 19a. Informant's Name/Relationship (Type, Print) Robert Green/son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3115 Foxhall Road NW Washington, DC 20016 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Date | | 20c. Location - City or Town, State |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Acute cerebrovascular accident b. Acute myocardial infarction c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | |
| | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | |
| | 23d. Date of delivery Month Day Year | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | |
| | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number 023170 | | 29d. Date signed (Month, Day, Year) May 12, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gita Dahiya MD Suburban Hospital | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature [Signature] | | | |

Ronald Hunt
04-02766
RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Unpend Item#23a,27, PPR ME C832, 6/21/04eg

1- For
State
Registrar

State of Maryland / Department of Health and Mental Hygiene

2004 15350

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ronald Hunt

2. Date of Death
Month Day Year
April 22, 2004

3. Time of Death
0325 P^M

4a. Facility Name (If not institution, give street and number)

Upper Chesapeake Medical Center

4b. City, Town, or Location of Death

Belair

4c. County of Death

Harford

5. Social Security Number
243-19-7300

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)
30 Yrs.

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

8. Date of Birth
(Month, Day, Year)
Dec. 26, 1973

9. Birthplace (State or Foreign
Country)
NC

Usual Residence of Decedent

10a. State
MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11 Osborne Rd

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.
Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
11

College (1-4 or 5+)
0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Randall Leadkey

18. Mother's Name (First, Middle, Maiden Surname)

Judy Hunt

19a. Informant's Name/Relationship (Type, Print)

Tyrone Hunt / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

259 Silo Drive Rowland NC 28360

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lumbert Memorial Gardens

Date

April 28, 2004

20c. Location - City or Town, State

Lumberton, NC

21. Signature of Funeral Service Licensee

Thomas P. Zizos

22. Name and Address of Facility

Charles L. Stevens Funeral Home Inc.
1501 East Fort Ave. Baltimore Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

Atherosclerotic Cardiovascular Disease

Approximate
Interval Between
Onset and Death

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an
autopsy
performed?
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☒ Yes 2 ☐ No

25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury
M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Patricia A. Pollak

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 23, 2004

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

PATRICIA ASONICA - POLLAK

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

John B. Smith

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15351

Certificate of Death

Reg. No.

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | |
|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Monica A. Headley | | 2. Date of Death Month 5 Day 9 Year 2004 | | 3. Time of Death 0032 M | |
| 4a. Facility Name (If not institution, give street and number) North Arundel Hospital | | 4b. City, Town, or Location of Death Glen Burnie | | 4c. County of Death Anne Arundel Co. | |
| 5. Social Security Number 578-06-4556 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | |
| 8. Date of Birth (Month, Day, Year) 8-26-35 | | 9. Birthplace (State or Foreign Country) Jamaica | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State NJ | | 10b. County Burlington | | 10c. City, Town or Location Westampton | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 72 Rolling Hills | | 10f. Zip Code 08060 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) 12th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurses Assistant | | 16b. Kind of Business/Industry Healthcare | |
| 17. Father's Name (First, Middle, Last) Alfred Campbell | | 18. Mother's Name (First, Middle, Maiden Surname) Ena Mae Morrison | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marie Benjamin | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1419 Cowsill Ave., Severn, Md. 21144 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Denbigh Cem. | | 20c. Location - City or Town, State Clarendon, Jamaica | |
| 21. Signature of Funeral Service Licensee Bladys Wane | | 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) a. CARDIO MYOPATHY | | | | | |
| Due to (or as a consequence of): | | | | | |
| b. Due to (or as a consequence of): | | | | | |
| c. Due to (or as a consequence of): | | | | | |
| d. Due to (or as a consequence of): | | | | | |
| Approximate Interval Between Onset and Death SEVEN (7) YEARS | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Norma S. Smith | | 29c. License number D41240 | | 29d. Date signed (Month, Day, Year) 05/10/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORMA S. SMITH, 2905 MITCHELLVILLE RD #104, BOWIE MD 20716 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature James B. Sparks | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Headley Monica
Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15352

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|---|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Patricia Holland | | | | 2. Date of Death Month Day Year MAY 9, 2004 | | | | 3. Time of Death 8:40 P M | |
| | 4a. Facility Name (If not institution, give street and number) CITIZENS NURSING HOME | | | | 4b. City, Town, or Location of Death FREDERICK | | | | 4c. County of Death FREDERICK | |
| Funeral Director | 5. Social Security Number 066-24-3126 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) 09/11/1930 | | 9. Birthplace (State or Foreign Country) LANCASTER, NY | |
| | 10a. State MARYLAND | | | | 10b. County FREDERICK | | 10c. City, Town or Location DETOUR | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 11053 HAUGHS CHRUCH ROAD | | | | 10f. Zip Code 21757 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOOD SERVICE | | 16b. Kind of Business/Industry CAFETERIA | | | |
| | 17. Father's Name (First, Middle, Last) ALLEN ERNEST BULL | | | | 18. Mother's Name (First, Middle, Maiden Sumame) EDNA M. NOLL | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) JANEL C. HOLLAND-LINN (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11053 HAUGHS CHURCH ROAD, DETOUR, MARYLAND 21757 | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BAYVIEW CREMATORY | | Date 5/12/2004 | | 20c. Location - City or Town, State BALTIMORE, MARYLAND | | | |
| | 21. Signature of Funeral Service Licensee <i>Kelly Gregory Fink</i> KELLY GREGORY FINK #MD1148 | | | | 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cirrhosis of liver | | | | | | | | Approximate Interval Between Onset and Death 5 yrs | |
| | 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Gene F. Ashe</i> | | | | 29c. License number D0031058 | | 29d. Date signed (Month, Day, Year) 5-11-04 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene F. Ashe, MD 10200 Coppermine Rd, PO Box 6 Woodsboro, MD 21798 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | | | 32. Registrar's Signature <i>John H. Smith</i> | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

William T. Hobbs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK 04-119

04-2390

AKG

1- For
State
RegistrarUnpend Item #23a, 27, 28a-1 per me 6831 5/14/04 tas
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

2004 15353

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Thomas Hobbs

2. Date of Death

Month Day Year
April 7, 2004

3. Time of Death

10:10 A^M

4a. Facility Name (If not institution, give street and number)

4700 block of Pulaski Highway

4b. City, Town, or Location of Death

Belcamp

4c. County of Death

Harford

5. Social Security Number

414-26-8545

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
4 6 26

9. Birthplace (State or Foreign Country)

TENN

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

700 W. Belair Ave

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1946-1967

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

U.S. NAVY

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

DELLA Hobbs WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

MT. Zoar Rd, CONOWINGO 21918

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GREENMOUNT Crematory

Date

5-13-04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHAPMAN-HARRIS F.H. 5204 Reisterstown Rd Baltimore

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

At scene

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

4/7/2004

28b. Time of Injury

10:00

A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject Struck By Train

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4700 Block of Pulaski Hwy., Belcamp, Md

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 8, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Z. Ali M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15354

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ARTHUR ALBERT HANSON | | | | | | 2. Date of Death Month Day Year MAY 10 2004 | | 3. Time of Death 1445 M | |
| | 4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center | | | | 4b. City, Town, or Location of Death Bel Air | | | 4c. County of Death Harford | | |
| Funeral Director | 5. Social Security Number 212-40-7096 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 60 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 28, 1943 | | 9. Birthplace (State or Foreign Country) New Jersey | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County Harford | | 10c. City, Town or Location Fallston | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 1616 Watervale Road | | | | 10f. Zip Code 21047 | | | 10g. Citizen of What Country? United States | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) self-employed (owner) | | | 16b. Kind of Business/Industry liquor store | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Arthur Hanson | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Katherine Hammel | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Barbara Hanson/wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1616 Watervale Road, Fallston, Md. 21047 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Highview Memorial Gdns. 5/14/04 | | | 20c. Location - City or Town, State Fallston, Md. | | | |
| | 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. SMALL CELL LUNG CANCER | | | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SMALL CELL LUNG CANCER, HYPOXIA, PROSTATE CANCER, PARANEOPLASTIC SYNDROME | | | | | | | | | |
| | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | | | | | | | | |
| | 23d. Date of delivery Month Day Year | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier Dr. John Byrne DO (BYRNE) | | | | | | 29c. License number H-59435 | | 29d. Date signed (Month, Day, Year) MAY 10, 2004 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR JOHN BYRNE 500 UPPER CHESAPEAKE - BEL AIR, MD 21014 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15355

Certificate of Death

Reg. No.

1- For
State
Registrar

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BETTY MAXINE JONES | | | | 2. Date of Death Month MAY 12, Day 2004 Year | | 3. Time of Death 12:50a.M | |
| | 4a. Facility Name (If not institution, give street and number) 7914 33rd Street | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 235-30-5234 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) 7-3-1924 | |
| | 9. Birthplace (State or Foreign Country) WEST VIRGINIA | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location ROSEDALE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 7914 33RD STREET | | 10f. Zip Code 21237 | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASSEMBLER | | | | 16b. Kind of Business/Industry WESTERN ELECTRIC | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) JAMES YANERO | | | | 18. Mother's Name (First, Middle, Maiden Surname) LAURA (GLOVER) | | | |
| | 19a. Informant's Name/Relationship (Type, Print) ROGER M. JONES (HUSBAND) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7914 33RD STREET ROSEDALE, MD 21237 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY MEM. | | 20c. Location - City or Town, State 5-15-2004 TIMONIUM, MD | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CVA | | | | Approximate Interval Between Onset and Death | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Hypertension | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | |
| | 23d. Date of delivery Month Day Year | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | | |
| | 28b. Time of Injury M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and Title of Certifier | | | |
| | 29c. License number D22627 | | | | 29d. Date signed (Month, Day, Year) 5/13/04 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F. SAUZARO MD, 3346 Peach Mill Rd, Phoenix MD | | | | 31. Date (Month, Day, Year) MAY 13 2004 | | | |
| | 32. Registrar's Signature | | | | 33. Date (Month, Day, Year) 01131 | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15356

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 903-681-9036.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

| | | | | | | | | |
|--|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>ANNA K JOHNSON</u> | | | | 2. Date of Death Month <u>MAY</u> Day <u>8</u> Year <u>2004</u> | | 3. Time of Death <u>6:50 P M</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Howard County General Hospital</u> | | | | 4b. City, Town, or Location of Death <u>Columbia MD</u> | | 4c. County of Death <u>Howard</u> | |
| Funeral Director | 5. Social Security Number <u>191-03-0331</u> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>89</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>Aug. 22, 1914</u> | |
| | 9. Birthplace (State or Foreign Country) <u>PA</u> | | 10a. State <u>MD</u> | | 10b. County <u>Howard</u> | | 10c. City, Town or Location <u>Ellicott City</u> | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number <u>300 North Ridge Road</u> | | 10f. Zip Code <u>21043</u> | | 10g. Citizen of What Country? <u>USA</u> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify <u>white</u> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Cafeteria Worker</u> | | 16b. Kind of Business/Industry <u>School District</u> | | | | |
| 17. Father's Name (First, Middle, Last) <u>Leon Kasnevich</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Nellie Wardholak</u> | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Maryann Johnson / Daughter</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5969 Montgomery Road, ElkrIDGE MD 21075</u> | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Lawn Haven Cem. May 13, 2004</u> | | 20c. Location - City or Town, State <u>East Franklin Township, PA</u> | | | | |
| 21. Signature of Funeral Service Licensee <u>Victor P. Doda, Jr.</u> | | 22. Name and Address of Facility <u>Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230</u> | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>ACUTE RENAL FAILURE</u> Due to (or as a consequence of): <u>UROSEPSIS</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>DAY 1</u> <u>DAY 5</u> | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one). Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <u>[Signature]</u> | | 29c. License number <u>D0053150</u> | | 29d. Date signed (Month, Day, Year) <u>MAY 10 2004</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>SHAWN MATA CUPTA 201-1096 ACH RIVER NECK MD 21221</u> | | 31. Date filed (Month, Day, Year) <u>MAY 13-2004</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15357

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jane D. Knabe | | | | 2. Date of Death Month Day Year May 13, 2004 | | | | 3. Time of Death 10:00A M | |
| | 4a. Facility Name (If not institution, give street and number) 9403 Clocktower Lane | | | | 4b. City, Town, or Location of Death Columbia | | | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 071-24-0397 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) APR 15, 1930 | | 9. Birthplace (State or Foreign Country) New York | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Arnold | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 1207 Brunswick Court | | | | 10f. Zip Code 21012 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant | | | | 16b. Kind of Business/Industry Church | | | | 17. Father's Name (First, Middle, Last) Ralph Diefenbach | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Leila Winters | | | | 19a. Informant's Name/Relationship (Type, Print) Timothy A. Knabe/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 Cedarbrooke Place Baltimore, MD 21236 | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | | | 20c. Location - City or Town, State Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee Edward A. Gregorchik | | | | 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoid lung cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | |
| | 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Daughter's Residence | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | | | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Bingta E Miller MD | | | | 29c. License number D50152 | | |
| 29d. Date signed (Month, Day, Year) May 13, 2004 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bingta E Miller MD 2003 Medical Parkway Suite 100 Annapolis MD | | | | 31. Date (Month, Day, Year) MAY 13 2004 | | |
| 32. Registrar's Signature B. Sparks | | | | 33. Date (Month, Day, Year) MAY 13 2004 | | | | 34. Signature J. Sparks | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15358

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Stavroula Karalekas

2. Date of Death

May 8, 2004

3. Time of Death

7:30 a m

4a. Facility Name (If not institution, give street and number)

320 Huntsman Court

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

047-32-9797

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug. 7, 1928

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Md.

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

320 Huntsman Court

10f. Zip Code

21015

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

seamstress

16b. Kind of Business/Industry

clothing/retail

17. Father's Name (First, Middle, Last)

Meletios Gianakos

18. Mother's Name (First, Middle, Maiden Surname)

Steliani Lumakos

19a. Informant's Name/Relationship (Type, Print)

George G. Karalekos/ son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1806 Bayonne Court, Bel Air, Md. 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Demetrios Ch. Cem. 5/11/04

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.

610 W. MacPhail Road, Bel Air, Md. 21014

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Chronic Renal Failure

Due to (or as a consequence of):

b. Multiple Myeloma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 yr 8 months

2 yrs 7 months

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT DANEKAR

6569 N. Charles St

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

Brenda G. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15359

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Joseph Kelly Sr.

2. Date of Death

Month
MayDay
10Year
2004

3. Time of Death

8:05 A.M.

4a. Facility Name (If not institution, give street and number)

322 W. Arden Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

219 18 9030

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 9, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

322 W. Arden Road

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Inspector

16b. Kind of Business/Industry

Motor Vehicle Adm.

17. Father's Name (First, Middle, Last)

William Leo Kelly

18. Mother's Name (First, Middle, Maiden Surname)

Marie Reichert

19a. Informant's Name/Relationship (Type, Print)

Dolores Kelly / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

322 W. Arden Road Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Mem. Park

Date

5/13/2004

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Dorothy Bromisowski

22. Name and Address of Facility

Gonce Funeral Service, P.A.

4001 Ritchie Highway Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. COLON CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 months

IF FEMALE

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION
CONGESTIVE HEART FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

FER EREN MD

29c. License number

055506

29d. Date signed (Month, Day, Year)

05/11/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FER EREN MD 3721 Potosi Street Baltimore, MD 21225

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

Brenda B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1. For State Registrar

Amend Item 4b per Dr., 6831, 05/13/04dhb

Certificate of Death

Reg. No.

2004 15360

| | | | | | | | | | | |
|--|---|---------------------------------|---|---|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) YEFIM KOPMAN | | | | 2. Date of Death Month May Day 10 Year 2004 | | | | 3. Time of Death 2:25A M | |
| | 4a. Facility Name (If not institution, give street and number) Northwest Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 217-37-1496 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) APR. 18, 1919 | | 9. Birthplace (State or Foreign Country) UKRAINE | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 1500 BEDFORD AVENUE #319 | | | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CIVIL ENGINEER | | | 16b. Kind of Business/Industry GOVERNMENT | | | |
| 17. Father's Name (First, Middle, Last) CHIAM KOPMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname) YAHID TSICMAN | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) DORA KOPMAN / WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 BEDFORD AVENUE #319 - BALTIMORE, MD 21208 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW CEM. | | Date 5/11/2004 | | 20c. Location - City or Town, State REISTERSTOWN, MD | | |
| 21. Signature of Funeral Service Licensee <i>Michael Brown</i> | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic pancreatic carcinoma | | | | | | | | | | |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23a. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Ramaswamy I Ramaswamy MD</i> | | | | 29c. License number DS4288 | | 29d. Date signed (Month, Day, Year) May 10th 2004 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramaswamy I Ramaswamy Northwest Hospital Center | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | | | 32. Registrar's Signature <i>Brown & Sparks</i> | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Certificate of Death

Reg. No.

2004 15361

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Billie Kay Lancaster

2. Date of Death

May 12 2004

3. Time of Death

7:59AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

220-36-5922

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 9, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

White Marsh

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1134 Pulaski Highway #6

10f. Zip Code

21162

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Barmaid

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

William Lancaster

18. Mother's Name (First, Middle, Maiden Surname)

UNK.

19a. Informant's Name/Relationship (Type, Print)

Joseph Cimino, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9524 Hallhurst Road Baltimore, MD 21236

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

5-13-04

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility

Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic Encephalopathy

Due to (or as a consequence of):

b. MI

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael Suter

29c. License number

D44604

29d. Date signed (Month, Day, Year)

May 12, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Michael Suter 900 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

Sharon B. Sparks

State
RegistrarLancaster, Billie
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15362

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT

LEE

2. Date of Death

Month Day Year

MAY 03 2004

3. Time of Death

10:05 AM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

NA

Funeral
Director

5. Social Security Number

218-62-3934

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

3-24-55

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1836 N. Bond Street

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

Benjamin

18. Mother's Name (First, Middle, Maiden Surname)

Bostick

19. Informant's Name/Relationship (Type, Print)

Jeffrey Bostick

20. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Brother

19a. Informant's Name/Relationship (Type, Print)

Jeffrey Bostick

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1836 N. Bond Street, Baltimore, Md. 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Carmel Cem.

Date

5-8-04

20c. Location - City or Town, State

Dundalk, Md.

21. Signature of Funeral Service Licensee

K. Lady Wane

22. Name and Address of Facility

March F.H. East

Baltimore, Md. 21202

1101 E. North Ave.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. ASPIRATION PNEUMONIA
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death
24 HoursSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. RETROVIRAL INFECTION
Due to (or as a consequence of):

6 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Christ M. Doyle MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MAY 03, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTINE TOMPKINS

JOHNS HOPKINS HOSPITAL

600 NORTH WOLFE STREET

BALTIMORE MD 21287

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 17.19a State of Maryland / Department of Health and Mental Hygiene 2004 15363
 1- For State Registrar 8 per FH, 6831.05/13/04bb Certificate of Death Reg. No.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | |
|---|---------------------------------|---|---|---|
| 1. Decedent's Name (First, Middle, Last) CHARLES LEISURE | | 2. Date of Death Month MAY Day 10 Year 2004 | | 3. Time of Death 4:00 P M |
| 4a. Facility Name (If not institution, give street and number) 7016 FIELDCREST ROAD | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| 5. Social Security Number 185-26-4687 | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 84 Yrs. | 8. Date of Birth (Month, Day, Year) MAY 5, 1920 | 9. Birthplace (State or Foreign Country) POLAND |
| Usual Residence of Decedent | | | | |
| 10a. State MD | 10b. County N/A | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits 1 Yes 2 No |
| 10e. Street and Number 7016 FIELDCREST ROAD | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: |
| 14. Race - American Indian, Black, White, etc. WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TAILOR | | 16b. Kind of Business/Industry CLOTHING | | |
| 17. Father's Name (First, Middle, Last) FRANK Isaac Lieserowicz LIESEROWICZ | | 18. Mother's Name (First, Middle, Maiden Surname) ESTHER UNOBTAINABLE | | |
| 19a. Informant's Name/Relationship (Type, Print) Urszula Wlodarczyk Leisure - Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7016 FIELDCREST ROAD BALTIMORE, MD 21215 | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW | | 20c. Location - City or Town, State 05/12/2004 REISTERSTOWN, MD |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD PIKESVILLE, MD | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic obstructive pulmonary disease Hypertension | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | | 23d. Date of delivery Month Day Year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| 24a. Was an autopsy performed? 1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day Year) M | | 28b. Time of Injury 1 Yes 2 No |
| 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier | | 29c. License number D 300009 | | 29d. Date signed (Month, Day, Year) 05/11/04 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Milan Wisten, no 4000 old Court Rd; Baltimore, no 21208 | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 15364

| | | | | | | | | |
|---|---|--|---|--|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Henrietta M. Lhotsky</i> | | | | 2. Date of Death Month <i>May</i> Day <i>8</i> Year <i>2004</i> | | 3. Time of Death <i>6:45 A M</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>Ivy Hall Geriatric & Rehab. Center</i> | | | | 4b. City, Town, or Location of Death <i>Middle River</i> | | 4c. County of Death <i>Baltimore</i> | |
| Funeral Director | 5. Social Security Number <i>213-68-0155</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>101</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>Jan. 30, 1903</i> | |
| | 9. Birthplace (State or Foreign Country) <i>Czechoslovakia</i> | | 10a. State <i>Maryland</i> | | 10b. County <i>N/A</i> | | 10c. City, Town or Location <i>Baltimore</i> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number <i>5847 Daybreak Terrace</i> | | | |
| | 10f. Zip Code <i>21206</i> | | | | 10g. Citizen of What Country? <i>U. S. A.</i> | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | |
| | 15. Decedent's Education (Specify only highest grade completed) <i>6th Grade</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i> | | 16b. Kind of Business/Industry <i>Own Home</i> | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) <i>Jerry Herman</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Matilda Mildred Fikavtona</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>James J. Lhotsky (Son)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5847 Daybreak Terrace, Baltimore, Maryland 21206</i> | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Most Holy Redeemer</i> | | 20c. Location - City or Town, State <i>Baltimore, Maryland</i> | | 20d. Date <i>5/11/2004</i> | |
| | 21. Signature of Funeral Service Licensee <i>Brian G. Ueller</i> | | 22. Name and Address of Facility <i>Schimunek Funeral Homes 3331 Brehms Lane, Baltimore, Maryland 21213</i> | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Ischemic Cardiomyopathy</i> | | | | | | | Approximate Interval Between Onset and Death <i>un-known</i> |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia, Coronary artery disease, COPD, Chronic Renal insufficiency, Dementia</i> | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month <i>May</i> Day <i>10</i> Year <i>2004</i> | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27a. Date of Injury (Month, Day, Year) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>MD</i> | | 29c. License number <i>D-38754</i> | | 29d. Date signed (Month, Day, Year) <i>05-10-2004</i> | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MALIKA WASSEM, 709 EASTERN BLVD - MD - 21221</i> | | | | | | | |
| | 31. Date filed (Month, Day, Year) <i>MAY 13 2004</i> | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15365

1- For
State
Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DEBORA LLOYD

2. Date of Death

May 1, 2004

3. Time of Death

0455 A M

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

213-90-3734

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUN-20-1963

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

PASADENA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

615 POWHATTON BEACH RD.

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

FIRE RESTORATION

17. Father's Name (First, Middle, Last)

ERNIE MORLAN

18. Mother's Name (First, Middle, Maiden Surname)

FRAN NICE

19a. Informant's Name/Relationship (Type, Print)

JERRY LLOYD, HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

615 POWHATTON BEACH RD. PASADENA, MD. 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BAYVIEW CREMATORY

Date

5-8-04

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Daugherty Family Funeral Home And Cremation Center, P.A.
2601 Mountain Road Pasadena, MD. 21122

23. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary thromboembolism

Due to (or as a consequence of):

b. Bilateral deep vein thrombosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anoxic encephalopathy

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]
ZAKIULLAH ALI

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 2, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAKIULLAH ALI

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15366

| | | | | | | | | |
|---|---|--|--|--|---|--------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Charles K. Linthicum JR.</u> | | | | 2. Date of Death Month <u>May</u> Day <u>11</u> Year <u>2004</u> | | 3. Time of Death <u>625 A.M.</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Mercy Medical Center</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>N/A</u> | |
| Funeral Director | 5. Social Security Number <u>220 20 2711</u> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>75</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <u>June 6, 1928</u> | 9. Birthplace (State or Foreign Country) <u>Maryland</u> |
| | Usual Residence of Decedent | | | | 10a. State <u>Maryland</u> | | 10b. County <u>N/A</u> | |
| To Be Completed by Funeral Director | 10c. City, Town or Location <u>Baltimore</u> | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number <u>3915 Inner Circle</u> | |
| | 10f. Zip Code <u>21225</u> | | | | 10g. Citizen of What Country? <u>U.S.</u> | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4th</u> College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Laborer</u> | | 16b. Kind of Business/Industry <u>A & P Tea Company</u> | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) <u>Charles Linthicum Sr.</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Florence Nagle</u> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>Vicky Schertle / Daughter</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>384 Church Street Glen Rock, Pennsylvania 17327</u> | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Cedar Hill Cemetery</u> | | 20c. Location - City or Town, State <u>5/13/04 Baltimore, Maryland</u> | |
| | 21. Signature of Funeral Service Licensee <u>Dan Brzezinski</u> | | | | 22. Name and Address of Facility <u>Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225</u> | | | |
| Physician /Medical Examiner | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death) a. <u>Conduction system</u> Due to (or as a consequence of): b. <u>Acute valve disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Pneumonia</u> | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) <u>M</u> 28b. Time of Injury <u>1</u> Yes <input type="checkbox"/> No <input type="checkbox"/> No | | | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| State Registrar | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <u>Louis E. Grenzer M.D.</u> | | | | 29c. License number <u>D01442</u> | | 29d. Date signed (Month, Day, Year) <u>May 11, 2004</u> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Louis E. Grenzer, M.D. 301st R-1 Plac # 815 Baltimore</u> | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) <u>MAY 18 2004</u> | | | | 32. Registrar's Signature <u>[Signature]</u> | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15367

1- For State Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Solomon Leon | | | | 2. Date of Death Month 5 Day 10 Year 2004 | | 3. Time of Death 9:23 A.M. | |
| 4a. Facility Name (If not institution, give street and number) Baltimore Vet Admin | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| 5. Social Security Number 217-30-4442 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) 11/28/1930 | |
| 9. Birthplace (State or Foreign Country) MD | | | | | | | |

Funeral
Director

| | | | |
|--|---------------------------|---|--|
| Usual Residence of Decedent | | | |
| 10a. State MD | 10b. County N/A | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |

| | | | | | |
|--|--|-------------------------------|--|--|--|
| 10e. Street and Number 4158 CRESTHEIGHTS RD. | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. | |
|--|--|-------------------------------|--|--|--|

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
|--|--|---|--|--|--|---|--|

| | | | | | |
|---|--|--|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WAREHOUSEMAN | | 16b. Kind of Business/Industry CLOTHING | |
|---|--|--|--|---|--|

| | | | |
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| 17. Father's Name (First, Middle, Last) JOSEPH LEON | | 18. Mother's Name (First, Middle, Maiden Surname) LENA FINE | |
|---|--|---|--|

| | | | |
|--|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print) JAMIE LEON / NEPHEW | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12421 DIPLOMA DR. REISTERSTOWN, MD 21136 | |
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| | | | | | |
|---|--|--|--|--|--|
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH YEHODA ANSHE KURLAND | | 20c. Location - City or Town, State 05/12/2004 BALTIMORE, MD | |
|---|--|--|--|--|--|

| | | | |
|--|--|---|--|
| 21. Signature of Funeral Service Licensee <i>Michael B...</i> | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLES, MD 21208 | |
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| | | | |
|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COLON CANCER | | Approximate Interval Between Onset and Death 2 years | |
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| | | | | | | | | | |
|--|--|-------------------------------------|--|-------------------------------------|--|-------------------------------------|--|-------------------------------------|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a. Due to (or as a consequence of): | | b. Due to (or as a consequence of): | | c. Due to (or as a consequence of): | | d. Due to (or as a consequence of): | |
|--|--|-------------------------------------|--|-------------------------------------|--|-------------------------------------|--|-------------------------------------|--|

| | | | | | |
|---|--|---|--|---|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
|---|--|---|--|---|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
|--|--|--|--|--|--|--|--|

| | | | |
|---|--|--|--|
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
|---|--|--|--|

| | | | |
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| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |

| | | | | | | | |
|---|--|---|--|-------------------------------------|--|---|--|
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Cheryl M...</i> | | 29c. License number P1779 | | 29d. Date signed (Month, Day, Year) 5/10/04 | |
|---|--|---|--|-------------------------------------|--|---|--|

| | |
|--|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anjali Mehta 23 South Greene St, Baltimore MD | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | |
| 32. Registrar's Signature <i>Benjamin B. Sparks</i> | |

State
Registrar

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 15368

| | | | | | | | | | | |
|---|---|--|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Snell McGriff, Jr. | | | | 2. Date of Death Month 5 Day 8 Year 2004 | | | | 3. Time of Death 8:p M | |
| | 4a. Facility Name (If not institution, give street and number) 1538 Homestead St. | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 259-28-6614 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) 3-10-22 | | 9. Birthplace (State or Foreign Country) Ga. | |
| | 10a. State Md. | | | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 1535 Homestead Street | | | | 10f. Zip Code 21218 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Mill | | | | 16b. Kind of Business/Industry Bethlehem Steel | | | | 17. Father's Name (First, Middle, Last) Snell McGriff, Sr. | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Sally Tillman | | | | 19a. Informant's Name/Relationship (Type, Print) Viola McGriff Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1535 Homestead St., Baltimore, Md. 21218 | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cem. | | | | 20c. Location - City or Town, State Baltimore, Md. | |
| | 21. Signature of Funeral Service Licensee Glady Wane | | | | 22. Name and Address of Facility Baltimore, Md. 21202 | | | | 22. Name and Address of Facility March F.H. East 1101 E. North Ave. | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MULTIPLE MYELOMA | | | | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) | |
| | 23d. Date of delivery Month Day Year | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier [Signature] | | |
| 29c. License number D29071 | | | | 29d. Date signed (Month, Day, Year) 5/10/04 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANANDA KUTZMAN 821 NIEUZAN ST BALTIMORE MD 21201 | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15369

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|--|---|--|--|--|--|--|---|-------------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Vera Wenk Mays | | | | | | 2. Date of Death Month Day Year May 11, 2004 | | | 3. Time of Death 6:00 P M | |
| | 4a. Facility Name (If not institution, give street and number) Collingswood Nursing Home | | | | 4b. City, Town, or Location of Death Rockville | | | 4c. County of Death Montgomery | | | |
| Funeral Director | 5. Social Security Number 579-24-4549 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) 08/28/1924 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number 13504 Oriental Street | | | | 10f. Zip Code 20853 | | 10g. Citizen of What Country? U.S.A. | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own home | | | |
| | 17. Father's Name (First, Middle, Last) Ernest Colon Wenk | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gertrude L. Garner | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Donald Mays / Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13504 Oriental Street, Rockville, Maryland 20853 | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Balt-Wash Crematory | | Date 05/13/2004 | | 20c. Location - City or Town, State Laurel, Maryland | | | | |
| | 21. Signature of Funeral Service Licensee Kenya Stewart 401338 | | | | 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) dementia Approximate Interval Between Onset and Death years | | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier St. Doh | | 29c. License number D.20148 | | 29d. Date signed (Month, Day, Year) May 11 2004 | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Dolinsky 911 Russell Ave, Gaithersburg Md. | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature [Signature] | | | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15370

| | | | | | | | | |
|---|--|--|---|--------------------------------|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Ernest M. Maulbetsch</u> | | | | 2. Date of Death Month <u>May</u> Day <u>12</u> Year <u>2004</u> | | 3. Time of Death <u>1:20 A.M.</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Oakcrest Village, Apt 2501, 8800 Walther Blvd</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>Baltimore</u> | |
| Funeral Director | 5. Social Security Number <u>092-07-8738</u> | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>87</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <u>July 2, 1916</u> | | 9. Birthplace (State or Foreign Country) <u>Germany</u> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <u>Md.</u> | 10b. County <u>Baltimore</u> | 10c. City, Town or Location <u>Baltimore</u> | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number <u>8800 Walther Blvd, Apt. 2501</u> | | | 10f. Zip Code <u>21234</u> | | 10g. Citizen of What Country? <u>USA</u> | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Past Office Clerk</u> | | 16b. Kind of Business/Industry <u>U.S. Postal Service</u> | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) <u>Martin Maulbetsch</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Wilhelmina (surname unknown)</u> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>Roy Maulbetsch/Son</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3200 James Run Rd. Aberdeen, Md. 21001</u> | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Bayview Crematory</u> | | Date <u>5/13/2004</u> | | 20c. Location - City or Town, State <u>Baltimore, Md.</u> | |
| | 21. Signature of Funeral Service Licensee <u>J. S. Baglanis</u> | | 22. Name and Address of Facility <u>Schimunek Funeral Homes</u> <u>610 W. MacPhail Rd., Bel Air, Md. 21014</u> | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>CVA</u> Due to (or as a consequence of): <u>ASCVD</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>HTN, DM</u> | | | | | | Approximate Interval Between Onset and Death <u>months</u> <u>years</u> | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HTN, DM</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier <u>J. S. Baglanis</u> | | 29c. License number <u>D53115</u> | | 29d. Date signed (Month, Day, Year) <u>May 12th 2004</u> | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Jean Landrum 8800 Walther Blvd Parkville MD 21234</u> | | | | | | | |
| | 31. Date filed (Month, Day, Year) <u>MAY 13 2004</u> | | 32. Registrar's Signature <u>Bertha B. Sparks</u> | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 15371

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Estella

Matthews

2. Date of Death

Month

Day

Year

3. Time of Death

7:12 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sino Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

224-44-8825

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

03 09 31

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

3805 Monterey Road

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th grade

College (1-4 or 5+)

na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Private Duty

17. Father's Name (First, Middle, Last)

Leonard Franklin

18. Mother's Name (First, Middle, Maiden Surname)

Ida Mae Beachman

19a. Informant's Name/Relationship (Type, Print)

Vernon Ferebee-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

708 16th Street, Virginia Beach VA 23451

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

Date

5/15/04

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

Deborah Edge

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore Md

21215

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 min

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Breast Cancer

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

May 9 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avian Kida MD 2401 West Belvedere Avenue Baltimore Maryland 21215

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

Bennie B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1- For **Am**
State
Registrar

1- Amend Item 26 per Dr. G331, 05/13/04 dhd

Certificate of Death

Req. No.

2004 15372

1. Decedent's Name (First, Middle, Last) Janice White Nicholson 2. Date of Death Month May Day 10 Year 2004 3. Time of Death 4:20 p M

4a. Facility Name (If not institution, give street and number) 5 Firefly Circle, apt. H 4b. City, Town, or Location of Death Cockeysville 4c. County of Death Baltimore

5. Social Security Number 216-20-6874 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 78 Yrs. 8. Date of Birth (Month, Day, Year) Jan 28, 1926 9. Birthplace (State or Foreign Country) Maryland

10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Towson 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 305 E. Joppa Road, #506 10f. Zip Code 21286 10g. Citizen of What Country? USA

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: White

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper 16b. Kind of Business/Industry Real Estate

17. Father's Name (First, Middle, Last) Arthur Gantt White 18. Mother's Name (First, Middle, Maiden Surname) Edith Fern Wolf

19a. Informant's Name/Relationship (Type, Print) Robert Lee Nicholson/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Firefly Circle, apt. H, Cockeysville, MD 21030

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore-Washington Crematory 20c. Location - City or Town, State Laurel, Maryland

21. Signature of Funeral Service Licensee Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Fibrosis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximately Interval Between Onset and Death 5 years

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Son's Residence

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 020688 29d. Date signed (Month, Day, Year) 5/14/04

30. Name and address of person who completed cause of death (Use 23a) (Type, Print) Carl Friedman, M.D. 515 Fairmount Ave., suite 310, Towson, MD 21286

31. Date filed (Month, Day, Year) MAY 13 2004 32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHHM 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15373

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louis Nerf

2. Date of Death

May 12 2004

3. Time of Death

9:30 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-03-9086

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

May 16, 1917

9. Birthplace (State or Foreign
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4200 Garland Avenue

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Conductor

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

Charles Nerf

18. Mother's Name (First, Middle, Maiden Surname)

Helen Zorbs

19a. Informant's Name/Relationship (Type, Print)

Mrs. Lois Loewer (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4200 Garland Avenue, Baltimore, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oak Lawn Cemetery

Date

5/17/2004

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes
9705 Belair Rd., Baltimore, MD 2123623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death
2 years
33 yearsSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of ventricular fibrillation status-post
Automated Implantable Cardiac Defibrillator, Diabetes
Mellitus, History of Prostate Cancer

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

May 12, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Christine Lee, 4940 Eastern Avenue, Baltimore, MD 21224

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15374

1- For State Registrar

Certificate of Death

Reg. No.

Physician /Medical Examiner

Funeral Director

| | | | | | |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) <i>Lawrence O'Brien</i> | | 2. Date of Death Month <i>May</i> Day <i>11</i> Year <i>2004</i> <i>8:50P^M</i> | | 3. Time of Death | |
| 4a. Facility Name (If not institution, give street and number) <i>Baltimore Rehabilitation Extended Care Baltimore</i> | | 4b. City, Town, or Location of Death <i>Baltimore</i> | | 4c. County of Death <i>n/a</i> | |
| 5. Social Security Number <i>288-14-2587</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday) <i>78</i> Yrs. | |
| 8. Date of Birth (Month, Day, Year) <i>Dec 27, 1925</i> | | 9. Birthplace (State or Foreign Country) <i>Ohio</i> | | | |
| 10a. State <i>Maryland</i> | | 10b. County <i>n/a</i> | | 10c. City, Town or Location <i>Baltimore</i> | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number <i>100 North Athol Avenue</i> | | 10f. Zip Code <i>21229</i> | |
| 10g. Citizen of What Country? <i>United States</i> | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>military service member</i> | | 16b. Kind of Business/Industry <i>United States government</i> | |
| 17. Father's Name (First, Middle, Last) <i>Lawrence J. O'Brien</i> | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Teresa McDonald</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Veronica O'Brien - sister</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>100 North Athol Avenue, Baltimore, Maryland 21229</i> | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>New Cathedral Cemetery</i> | | 20c. Location - City or Town, State <i>Baltimore, Maryland</i> | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility <i>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229</i> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Adenocarcinoma of GI Tract</i> <i>b. Recurrent Urinary Tract Infection</i> <i>c. Diabetes mellitus</i> | | Approximate Interval Between Onset and Death <i>6 m</i> <i>years</i> <i>years</i> | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>pancreas tumor</i> <i>chronic obstructive pulmonary disease</i> | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <i>M</i> | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Augustin Chyu, MD</i> | |
| 29c. License number <i>D18298</i> | | 29d. Date signed (Month, Day, Year) <i>May 11, 2004</i> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>AUGUSTIN CHYU 3900 Lock Raven Blvd Baltimore, MD 21218</i> | |
| 31. Date filed (Month, Day, Year) <i>MAY 13 2004</i> | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15375

Certificate of Death

Reg. No.

1- For
State
Registrar

| | | | | | | | | |
|---|--|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARGARET E. PEYSER | | | | 2. Date of Death Month MAY Day 12 Year 2004 | | 3. Time of Death 1:35 A M | |
| | 4a. Facility Name (If not institution, give street and number) Northwest Hospital Center | | | | 4b. City, Town, or Location of Death Randallstown | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 215-12-1394 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) August 19, 1920 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3041 Fallstaff Road, #605-D | | 10f. Zip Code 21209 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Clerk | | 16b. Kind of Business/Industry City of Baltimore | | | | |
| 17. Father's Name (First, Middle, Last) Reinholt Schaefer | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Falk | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lauren Hudgins Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3955 Nemo Road, Randallstown, MD, 21133 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore-Washington Crem. | | 20c. Location - City or Town, State 05/14/04 Laurel, Maryland | | | | |
| 21. Signature of Funeral Service Licensee Christy B. Buse | | 22. Name and Address of Facility Loring Byers Funeral Directors Inc 8728 Liberty Road, Randallstown, Md, 21133-4784 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Renal Failure Gastrointestinal bleed | | 23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Unknown | | 23c. Date of delivery Month Day Year | | 23d. Date of death Month Day Year | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Joginder P Mehta M.D. | | 29c. License number 150041410 | | |
| 29d. Date signed (Month, Day, Year) May 12, 2004 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joginder P Mehta Northwest Hospital Center Randallstown MD 21133 | | 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature [Signature] | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15376

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Katherine S. Pratt

2. Date of Death

Month Day Year
May 6, 2004

3. Time of Death

10:20A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Quail Run Assisted Living Facility

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

216-05-7608

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 12, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1800 Watervale Road

10f. Zip Code

21047

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Louis Slembecker

18. Mother's Name (First, Middle, Maiden Surname)

Augusta Miller

19a. Informant's Name/Relationship (Type, Print)

Mr. George Slembecker (nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1800 Watervale Rd., Fallston, MD 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parkwood Cemetery

Date

5/10/2004

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes

9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)a. Due to (or as a consequence of):
Myocardial InfarctionSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
Alzheimer's Dementia

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Days

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)
Assisted Living

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D55306

29d. Date signed (Month, Day, Year)

MAY 7th 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENNIS H ODIE, M.D. 1232 RALE RD. BALTIMORE, MD 21237

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15377

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James W. Reid

2. Date of Death

Month Day Year
May 9 2004

3. Time of Death

10:00 a M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

203 Concord Road

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Queen Anne

5. Social Security Number

218-26-2703

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Nov. 14, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Queen Anne

10c. City, Town or Location

Chestertown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

203 Concord Road

10f. Zip Code

21620

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8 years

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

truck driver

16b. Kind of Business/Industry

steel

17. Father's Name (First, Middle, Last)

George Reid, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Edna Robinson

19a. Informant's Name/Relationship (Type, Print)

Mildred Reid/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

203 Concord Road, Chestertown, Md. 21620

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bel Air Mem. Gdns.

Date

5/12/2004

20c. Location - City or Town, State

Bel Air, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.

610 W. MacPhail Road, Bel Air, Md. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Recurrent Acute Myelogenous Leukemia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death
☐ Pregnant at time of death
☐ Unknown☐ Ectopic pregnancy
☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, type II diabetes

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an
autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person causing death (Item 23a) (Type, Print)

John C. Harrison Jr. M.D. 223 High Street, Chestertown Md 21620

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 15378
Certificate of Death

1- For State Registrar

Reg. No.

Physician /Medical Examiner

Funeral Director

| | | | | | |
|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last) LEWIS THEODORE ROBERTS | | | 2. Date of Death Month May Day 11 Year 2004 | | 3. Time of Death 10:35PM |
| 4a. Facility Name (If not institution, give street and number) 509 BEAUMONT RD | | | 4b. City, Town, or Location of Death SILVER SPRINGS | | 4c. County of Death MONTGOMERY |
| 5. Social Security Number 579-48-1363 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 70 Yrs. | 8. Date of Birth (Month, Day, Year) AUG 28, 1933 | | 9. Birthplace (State or Foreign Country) WASHINGTON D.C. |
| Usual Residence of Decedent | | | | | |
| 10a. State FL | 10b. County CHARLOTTE | 10c. City, Town or Location PUNTA GORDA | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 23405 HARBORVIEW RD #721 | | | 10f. Zip Code 33980 | | 10g. Citizen of What Country? UNITED STATES |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1953-1955 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHIEF ADMINISTRATIVE OFFICER GOVERNMENT | | 16b. Kind of Business/Industry |
| 17. Father's Name (First, Middle, Last) BERNARD L. ROBERTS | | | 18. Mother's Name (First, Middle, Maiden Surname) RUTH BROWN | | |
| 19a. Informant's Name/Relationship (Type, Print) MARY E. ROBERTS /WIFE | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23405 HARBORVIEW RD #721 PUNTA GORDA, FL 33980 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ANATOMY GIFTS REG | | 20c. Location - City or Town, State 5/12/04 HANOVER, MD | |
| 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Prostate Cancer | | | | | |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Second Residence | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D 39190 | | 29d. Date signed (Month, Day, Year) MAY 12, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH RILEY 3418 OLAND WOOD CT. SUITE 111 SILVER SPRINGS, MD 20832 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15379

1- For State Registrar **AMEND ITEM #19-2b PER FH G831 5/13/04** Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHNNIE R. RICHARDSON | | 2. Date of Death Month Day Year MAY 10, 2004 | | 3. Time of Death 4:48 PM |
| | 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 220 30 6816 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) JAN. 1, 1933 | | 9. Birthplace (State or Foreign Country) N. CAROLINA | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State MD. | 10b. County N/A | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number 1638 N. BROADWAY | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (1-4or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER | | 16b. Kind of Business/Industry JOHNS HOPKINS UNV. | | |
| | 17. Father's Name (First, Middle, Last) JESSIE RICHARDSON | | 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH BATTLE | | |
| | 19a. Informant's Name/Relationship (Type, Print) DEBORAH L. FOGG (NICE) | | 19b. Informant's Address (Street and Number, City or Town, State, Zip Code) 6307 LAUREL RUN AVE. BALTO, MD 21214 2809 THE ALAMEDA BALTIMORE, MD 21218 | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) mausoleum Green Mount Cem. | | 20b. Place of Disposition (Name of cemetery, crematory or other place) May 14/2004 Baltimore, Md. | | 20c. Location - City or Town, State |
| | 21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs</i> | | 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTIMORE, MD 21213 | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. CORONARY ARTERY DISEASE Due to (or as a consequence of): b. Dilated CARDIOMYOPATHY Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 13 13 13 |
| | Immediate Cause (Final disease or condition resulting in death) | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | |
| | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | | | |
| | 23d. Date of delivery Month Day Year | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| Medical Certification; To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> R/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | |
| | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier <i>Greg E. Clark, MD</i> | | 29c. License number D38033 | | 29d. Date signed (Month, Day, Year) 5/12/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 261 S. Highland Ave (BALTIMORE, MD) 21224 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 18 2004 | | 32. Registrar's Signature <i>James B. Sparks</i> | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- Amend Items 5, 10e per H, 881, 05/15/04ms
 State of Maryland Department of Health and Mental Hygiene
 Certificate of Death
 Reg. No. 2004 15380

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) STANLEY RABOW | | 2. Date of Death Month MAY Day 08 Year 2004 | | 3. Time of Death 1:36 P | |
| 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL | | 4b. City, Town, or Location of Death RANDALLSTOWN, MD | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 220-23-8991 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | |
| 8. Date of Birth (Month, Day, Year) DEC. 1, 1945 | | 9. Birthplace (State or Foreign Country) RUSSIA | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location REISTERSTOWN | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 109 GLYNDON DRIVE #3 | | 10f. Zip Code 21136 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SOCIOLOGIST | | 16b. Kind of Business/Industry SOCIOLOGY | |
| 17. Father's Name (First, Middle, Last) CONSTANTINE | | 18. Mother's Name (First, Middle, Maiden Surname) RABOW ESPHIRE FINKELSTEIN | | | |
| 19a. Informant's Name/Relationship (Type, Print) ELLA ZABROVSKY / WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 GLYNDON DRIVE #3 - REISTERSTOWN, MD 21136 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ARLINGTON CHIZUK AMUNO | | 20c. Location - City or Town, State BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STROKE LEFT SIDE | | | | | |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D53910 | | 29d. Date signed (Month, Day, Year) MAY 08, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A- MAHESHWARI, MD NORTHWEST HOSPITAL, RANDALLSTOWN, MD | | | | | |
| 31. Date filed (Month, Day, Year) MAY 18 2004 | | 32. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15381

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth L. Sparks

2. Date of Death
Month Day Year

5 5 2004

3. Time of Death

8:57a M

4a. Facility Name (If not institution, give street and number)

3707 Loch Raven Blvd.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

104-32-4743

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

4-22-39

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2502 Montebello Terrace

10f. Zip Code

21214

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4or 5+)

2 yrs

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Fund Raiser

16b. Kind of Business/Industry

Legislative Aide

17. Father's Name (First, Middle, Last)

James

Baxter

18. Mother's Name (First, Middle, Maiden Surname)

Bertha

Salley

19a. Informant's Name/Relationship (Type, Print)

Renee Sparks-Cuffie Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1314 E. 33rd Street, Baltimore, Md. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Long Island Nat. Cem. 5/11/2004

Date

20c. Location - City or Town, State

Farmingdale, N.Y.

21. Signature of Funeral Service Licensee

Renee Sparks-Cuffie

22. Name and Address of Facility

Baltimore, Md. 21202
March F.H. East 1101 E. North Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Colon cancer stage IV

Approximate Interval Between Onset and Death

11 mo

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Sister's Residence

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

V. Epstein MD

29c. License number

D0056239

29d. Date signed (Month, Day, Year)

May 6, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. Epstein 201 E. University Pkwy, Baltimore, MD 21218

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

Renee Sparks

State
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

ROBERT STYERS
04-3179
DAP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Unpend Item # 23, 27, 28-1 per me 68760/1/04 tas

2004 15382

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Robert Styers | | 2. Date of Death Month MAY Day 11 Year 2004 | | 3. Time of Death 4:05a M | |
| 4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL | | 4b. City, Town, or Location of Death BERLIN | | 4c. County of Death WORCESTER | |
| 5. Social Security Number 204-52-4119 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 33 Yrs. | |
| 8. Date of Birth (Month, Day, Year) APR 2, 1971 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | | |
| 10a. State PA | | 10b. County York | | 10c. City, Town or Location Dover | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 2001 Red Bank Road, #123 | | 10f. Zip Code 17315 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Siding Installer | | 16b. Kind of Business/Industry Siding Installation | |
| 17. Father's Name (First, Middle, Last) UNK. | | 18. Mother's Name (First, Middle, Maiden Surname) Judy UNK. | | | |
| 19a. Informant's Name/Relationship (Type, Print) Tammy R. Styers/Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Red Bank Road, #123 Dover, PA 17315 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 5-13-04 | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee Edward A. Gregorchik | | 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Head Injuries | | Approximate Interval Between Onset and Death | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) may 11, 2004 | | 28b. Time of Injury 3:27 A M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject Fell From Balcony | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 17 78th Street, Ocean City, Md | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Qued | | 29c. License number OCME | |
| 29d. Date signed (Month, Day, Year) MAY 11, 2004 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | Registrar's Signature [Signature] | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15383

1- For State Registrar **AMEND ITEM #31** per dvr 831 5/13/04 **Certificate of Death**

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JESSIE STEWART

2. Date of Death

Month Day Year
MAY 11, 2004

3. Time of Death

9:00 A M

4a. Facility Name (If not institution, give street and number)

502 N. LINWOOD AVE.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

244 30 5938

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT. 4, 1918

9. Birthplace (State or Foreign Country)

S. CAROLINA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

502 N. LINWOOD AVE.

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6TH

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

BALTIMORE CITY SCHOOL CAFETERIA

17. Father's Name (First, Middle, Last)

WILLIAM BROWN

18. Mother's Name (First, Middle, Maiden Surname)

SARAH

19a. Informant's Name/Relationship (Type, Print)

NORMA WALLER (NIECE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

502 N. LINWOOD AVE. BALTIMORE, MARYLAND 21205

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEMETERY

Date

MAY 18, 2004 BALTIMORE, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bahadine J. Scruggs

22. Name and Address of Facility

BALTO, MD

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON STREET 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Atherosclerotic coronary artery disease*

Due to (or as a consequence of):

b. *Hypertension*

Due to (or as a consequence of):

c. *Hypercholesterolemia*

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Congestive Heart Failure**Pulmonary Hypertension*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nina F. Everett

29c. License number

D46444

29d. Date signed (Month, Day, Year)

5/11/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nina F. Everett 2323 Orleans St; Baltimore MD 21224

31. Date filed (Month, Day, Year)

5/13/04 MAY 13 2004

32. Registrar's Signature

*Barbara B. Sparks*State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Unpend Item #23a-b, 27, PER ME, G831, 5/27/04 eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a-b, 27, 28a-f per me G832 6/1/04 tas
Certificate of Death
Reg. No. 2004 15384

| | | | | | | | | | | |
|---|--|--|---|--|--|---|---|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Michael James Swader | | | 2. Date of Death Month MAY Day 9 Year 2004 | | | 3. Time of Death 0845 A M | | | |
| | 4a. Facility Name (If not institution, give street and number) 214 ULLMAN ROAD | | | 4b. City, Town, or Location of Death PASADENA | | | 4c. County of Death ANNE ARUNDEL | | | |
| Funeral Director | 5. Social Security Number 218 78 7222 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 35 Yrs. | | 8. Date of Birth (Month, Day, Year) August 30, 1968 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Pasadena | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 214 Ullman Road | | | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? U.S. | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) 12th | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Audio / Stereo | | | 16b. Kind of Business/Industry Self employed | | | |
| | 17. Father's Name (First, Middle, Last) Gordie Swader | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gladys Horn | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Kelly Swader / Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 Ullman Road Pasadena, Maryland 21122 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park | | Date 5/14/2004 | | 20c. Location - City or Town, State Glen Burnie, Maryland | | |
| | 21. Signature of Funeral Service Licensee <i>Jerome Znamionki</i> | | | 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 | | | | | | |
| | 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Methadone intoxication b. Myocardial Hypertrophy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | Approximate Interval Between Onset and Death |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) 5-9-04 | | 28b. Time of Injury Unknown M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Unknown | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier <i>J. Aaron Locke MD</i> | | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) MAY 10, 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | | 32. Registrar's Signature <i>Benjamin B. Sparks</i> | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15385

Certificate of Death

Reg. No.

1- For State Registrar

| | | | | | | | |
|---|---|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Donald Lynn Scharf Sr. | | | 2. Date of Death Month May Day 11 Year 2004 | | 3. Time of Death 8:50 A M | |
| | 4a. Facility Name (If not institution, give street and number) 103 Woods Avenue | | | 4b. City, Town, or Location of Death Ferndale | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 213-32-0960 | | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 70 Yrs. | | 8. Date of Birth (Month, Day, Year) 2/9/1934 | |
| | 9. Birthplace (State or Foreign Country) Indiana | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | |
| | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Ferndale | | 10d. Inside City Limits 1 Yes 2 No |
| | 10e. Street and Number 103 Woods Ave. | | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Air Conditioning & Refrigeration | | 16b. Kind of Business/Industry Maryland Refrigeration | | |
| | 17. Father's Name (First, Middle, Last) Fred Scharf | | | 18. Mother's Name (First, Middle, Maiden Surname) Lillian Ziemer | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mrs. Gloria June Scharf/wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Woods Ave., Ferndale, MD 21061 | | | |
| | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation | | Date 5/11/2004 | | 20c. Location - City or Town, State Stevensville, MD |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | M01364 | | 22. Name and Address of Facility Singleton Funeral Home 1 Second Ave SW Glen Burnie MD 21061 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) | | 23d. Date of delivery Month Day Year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | |
| 24a. Was an autopsy performed? 1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> M.D. | | 29c. License number D39505 | | 29d. Date signed (Month, Day, Year) May 11, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yudhish Markan 305 Hospital Drive, Glen Burnie, MD. 21061 | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15386

1- For
State
Registrar

| | | | | | | | | |
|---|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) SARAH ELIZABETH TREASTER | | | | 2. Date of Death Month Day Year MAY 10, 2004 | | 3. Time of Death 6:45P M | |
| | 4a. Facility Name (If not institution, give street and number) MARINER HEALTH | | | | 4b. City, Town, or Location of Death OVERLEA | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 191-18-9586 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) 12/13/1922 | |
| | 9. Birthplace (State or Foreign Country) PA. | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Rosedale | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 8033 Edgewater Ave. | | 10f. Zip Code 21237 | |
| | 10g. Citizen of What Country? USA | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical | | 16b. Kind of Business/Industry Social Security Admin. | |
| | 17. Father's Name (First, Middle, Last) Thomas Hostetler | | | | 18. Mother's Name (First, Middle, Maiden Surname) Zeda McCloy | | | |
| | 19a. Informant's Name/Relationship (Type, Print) James Treaster SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8033 Edgewater Avenue Rosedale Maryland 21237 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oaklawn Cemetery | | Date 5/14/04 | | 20c. Location - City or Town, State Baltimore Md | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>CARCINOMA OF STOMACH</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 3 MONTHS | | | | | | | |
| | 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | | | | | | |
| | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | | | | | | |
| 23d. Date of delivery Month Day Year | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DEMENTIA</u> | | | | | | | |
| | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| | 29b. Signature and title of certifier | | 29c. License number 047945 | | 29d. Date signed (Month, Day, Year) MAY 11 2004 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARIS ALFON MD 7505 OLIVE PRIVE TOWSON MD 21204 | | | | | | | |
| | 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- Amend Item 16b per FH, 6831, 05/13/04
 State of Maryland / Department of Health and Mental Hygiene
 Certificate of Death
 Reg. No. 2004 15387

| | | | | | |
|---|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HAROLD TABERSHAW | | 2. Date of Death Month MAY Day 10 Year 2004 | | 3. Time of Death 5:50 A M |
| | 4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT CENTER | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE |
| Funeral Director | 5. Social Security Number 248-44-4739 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | 8. Date of Birth (Month, Day, Year) AUG. 5, 1923 | |
| | 9. Birthplace (State or Foreign Country) NY | | Usual Residence of Decedent | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County BALTIMORE | 10c. City, Town or Location OWINGS MILLS | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 9005 GROFFS MILL DRIVE | | 10f. Zip Code 21117 | | 10g. Citizen of What Country? U.S.A. |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OPTOMOLOGIST Optometrist | | 16b. Kind of Business/Industry MEDICAL | | |
| | 17. Father's Name (First, Middle, Last) MORRIS TABERSHAW | | 18. Mother's Name (First, Middle, Maiden Surname) GOLDIE POSNER | | |
| | 19a. Informant's Name/Relationship (Type, Print) SARENE TABERSHAW / WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9005 GROFFS MILL DRIVE - OWINGS MILLS, MD 21117 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) PARK OHEB SHALOM MEMORIAL Date 5/11/2004 | | |
| | 20c. Location - City or Town, State REISTERSTOWN, MD | | 21. Signature of Funeral Service Licensee <i>Michael Kruger</i> | | |
| | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic vascular disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | |
| 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. Signature and title of certifier <i>D Roggen MD</i> | | 29c. License number D35844 | | 29d. Date signed (Month, Day, Year) May 10 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D Roggen 5400 Old Court Road Randallstown MD 21133 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature <i>Benjamin B Sparks</i> | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15388

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

PHYLLIS A. THOMAS

2. Date of Death

May 7 2004

Day

Year

3. Time of Death

0620 M

4a. Facility Name (If not institution, give street and number)

UMMS DEATON

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

MD

Funeral Director

5. Social Security Number

212.50.5594

6. Sex

1 ☐ M 2 ☒ F XX

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

OCT 30, 1947

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No XX

10e. Street and Number

601 SOUTH CHARLES ST

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DISABLED

16b. Kind of Business/Industry

DISABLED

17. Father's Name (First, Middle, Last)

CAREY N. THOMAS

18. Mother's Name (First, Middle, Maiden Surname)

SHIRLEY E. EVANS

19a. Informant's Name/Relationship (Type, Print)

CHRISTOPHER L. THOMAS SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2001 WHISTLER AVE. BALTIMORE, MD 21230

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BAYVIEW CREMATORY, INC

Date

MAY 11, 2004 BALTIMORE, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FINK FUNERAL HOME, P.A.

426 CRAIN HWY SW GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrhythmias

Due to (or as a consequence of):

Atherosclerotic heart disease

b. Due to (or as a consequence of):

Diabetes mellitus

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
15 minutes

5 hrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

progressive multiple sclerosis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D30494

29d. Date signed (Month, Day, Year)

5/7/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN H. UNIVERSITY SPECIALTY HOSPITAL 601 SOUTH CHARLES ST BALTIMORE MD 21230

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division of Vital Records, P.O. Box 68760,

Phyllis A. Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15389

Certificate of Death

Reg. No.

1- For State Registrar

| | | | | | | | | | | | |
|--|---|--|---|--|--|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CAROLYN WILSON | | | 2. Date of Death Month Day Year MAY 8, 2004 | | | 3. Time of Death 5:00 M | | | | |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | 4b. City, Town, or Location of Death BALTIMORE | | | 4c. County of Death NA | | | | |
| Funeral Director | 5. Social Security Number 219-70-2738 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 46 Yrs. | | 8. Date of Birth (Month, Day, Year) 4-10-58 | | 9. Birthplace (State or Foreign Country) Md. | | |
| | 10a. State Md. | | | 10b. County NA | | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1809 St. Paul Street | | | 10f. Zip Code 21202 | | | 10g. Citizen of What Country? USA | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+) College | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed | | | 16b. Kind of Business/Industry NA | | | | | |
| 17. Father's Name (First, Middle, Last) Lee Curtis Bostic | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jane Gibson | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Jane Bostic Mother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1804 St. Paul St., Baltimore, Md. 21202 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cem. | | | 20c. Location - City or Town, State Baltimore, Md. | | | 20d. Date 5-17-04 | | |
| 21. Signature of Funeral Service Licensee M. Ladner Womack | | | | | | 22. Name and Address of Facility March F.H. East Baltimore, Md. 21202 1101 E. North Ave. | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Retroviral Syndrome | | | | | | | | | | Approximate Interval Between Onset and Death years | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Thrombocytopenia | | | | | | | | | | | |
| Anemia | | | | | | | | | | | |
| | | | | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | | 3. Ectopic pregnancy <input type="checkbox"/> Other (specify) | | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | | 26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier [Signature] | | | 29c. License number RES-000 | | | 29d. Date signed (Month, Day, Year) MAY 8, 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOCTOR ANAND PAREKH, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND, 21287 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | | 32. Registrar's Signature [Signature] | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15390

1- For State Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|---|---|--|---|--|--|--|--|--|---|--|--------------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) REAGAN WEBB | | | | 2. Date of Death Month MAY Day 12 Year 2004 | | | | 3. Time of Death 11 43 AM | | | | |
| | 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL | | | | 4b. City, Town, or Location of Death RANDALLSTOWN | | | | 4c. County of Death BALTIMORE | | | | |
| Funeral Director | 5. Social Security Number 244-16-1158 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan 16 1921 | | 9. Birthplace (State or Foreign Country) NC | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md | | 10b. County Carroll | | 10c. City, Town or Location Sykesville | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number 6317 Georgetown Blvd Apt E | | | | 10f. Zip Code 21784 | | 10g. Citizen of What Country? USA | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) truck driver | | 16b. Kind of Business/Industry transportation | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) George Albert Webb | | | | 18. Mother's Name (First, Middle, Maiden Surname) Asalie (maiden name unknown) | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Renna Barbara Webb Spiva (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7406 Second Ave., Sykesville, Md 21784 | | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation | | Date 5-13-04 | | 20c. Location - City or Town, State Sykesville, Md | | | | | | |
| | 21. Signature of Funeral Service Licensee Paige Haight Herbert | | 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784 | | | | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA | | | | | | | | Approximate Interval Between Onset and Death | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | | |
| | a. Due to (or as a consequence of): | | | | | | | | | | | | |
| | b. Due to (or as a consequence of): | | | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | |
| | 23d. Date of delivery Month Day Year | | | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | 29b. Signature and title of certifier C. Ravi | | 29c. License number D37333 | | 29d. Date signed (Month, Day, Year) MAY 12, 2004 |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. RAVI MD, NHC, BALTO. MD 21133 | | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature Bender B Spots | | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15391

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Bernard

Webb

2. Date of Death

May 1, 2004

3. Time of Death

3:10am M

4a. Facility Name (If not institution, give street and number)

Mariner Health of Greater Laurel

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince Georges

5. Social Security Number

231-015451

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 18, 1919

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14800 Fourth Street, 43 B

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

Unk.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Clerk

16b. Kind of Business/Industry

Coast Guard

17. Father's Name (First, Middle, Last)

Harry Webb, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Durham

19a. Informant's Name/Relationship (Type, Print)

Bernard Webb, Jr./ Grandchild

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

244 West 29th Street, Norfolk VA 29504

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parker Cemetery May 6, 2004

Date

20c. Location - City or Town, State

Rocky Mount, NC

21. Signature of Funeral Service Licensee

Thomas P. Zizos

22. Name and Address of Facility

Charles L. Stevens Funeral Home Inc.
1501 East Fort Ave. Baltimore Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of Prostate with Metastases

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis of Liver

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24721

29d. Date signed (Month, Day, Year)

May 2, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Sadut 14333 Laurel Bowie Rd. Laurel Md. 20708

31. Date filed (Month, Day, Year)

MAY 13, 2004

32. Registrar's Signature

Beyonce S. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15392

1- For State Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---------------------------|---|---|--|---------------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Adrienne Webb | | | | 2. Date of Death Month May Day 10 Year 2004 | | | | 3. Time of Death 9:00 PM | |
| | 4a. Facility Name (If not institution, give street and number) Sma Hospital of Baltimore | | | | 4b. City, Town, or Location of Death Baltimore City | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 423-94-9314 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) April 18, 1910 | | 9. Birthplace (State or Foreign Country) Alabama | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 105 Edgevale Rd. | | | | 10f. Zip Code 21210 | | | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | | | 16b. Kind of Business/Industry own home | | |
| 17. Father's Name (First, Middle, Last) James A. Wilson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Adrienne Gibson Bennett | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Bruce Webb/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Edgevale Rd. Baltimore, MD 21210 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Knights of Pythias | | Date May 13, 2004 | | 20c. Location - City or Town, State Russellville, Alabama | | |
| 21. Signature of Funeral Service Licensee John O. Mitchell | | | | 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Closed head injury Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Traumatic Subarachnoid Hemorrhage Potential for Bleeding | | | | | | | | | | |
| Approximate Interval Between Onset and Death 10 days 10 days | | | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) 5/31/04 | | 28b. Time of Injury 6:00 AM | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred Fell off bed while sleeping | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore City | | | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) 105 Edgevale Road | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Matthew J. McGint MD | | | | 29c. License number Res-000 | | |
| 29d. Date signed (Month, Day, Year) May 10, 2004 | | | | 29e. Date signed (Month, Day, Year) May 10, 2004 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew J. McGint MD | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sma Hospital of Baltimore | | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | | | 32. Registrar's Signature John O. Mitchell | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Patent: Adrienne Webb
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15393

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | |
|--|---|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last) Henry Lee Ward | | | 2. Date of Death Month MAY Day 08 Year 2004 | | 3. Time of Death 3:00 PM |
| 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death |
| 5. Social Security Number 245-58-2023 | 6. Sex XXM 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 02 07 40 |
| 9. Birthplace (State or Foreign Country) NC | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits XX Yes 2 <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 5022 Queensberry Ave | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) na | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled | | 16b. Kind of Business/Industry Disabled |
| 17. Father's Name (First, Middle, Last) Walter Beamon | | | 18. Mother's Name (First, Middle, Maiden Sumame) Annie Mae Thompson | | |
| 19a. Informant's Name/Relationship (Type, Print) Bettie L. Ward-Wife | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5022 Queensberry Ave, Baltimore Md 21215 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | 20c. Location - City or Town, State 5/13/04 Randallstown, Md | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colon Cancer | | | | | Approximate Interval Between Onset and Death 10 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier <i>Gabriela Szabo MD</i> | | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) May, 08, 2004 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GABRIELA SZABO MD 2401 WEST BELVEDERE AVE BALTIMORE MD 21215 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | | 32. Registrar's Signature <i>[Signature]</i> | | |

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15394

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert Lee Allen | | | | 2. Date of Death Month Day Year April 26, 2004 | | | | 3. Time of Death 5:34am M | | | |
| | 4a. Facility Name (If not institution, give street and number) 4701 Plata St. | | | | 4b. City, Town, or Location of Death Clinton | | | | 4c. County of Death Prince George | | | |
| Funeral Director | 5. Social Security Number 239-70-5989 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 60 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 22, 1944 | | 9. Birthplace (State or Foreign Country) North Carolina | | | |
| | Usual Residence of Decedent | | | | 10a. State Maryland | | | | 10b. County Prince George | | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Clinton | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 4701 Plata Street | | | |
| | 10f. Zip Code 20735 | | | | 10g. Citizen of What Country? United States | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | |
| | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1983 | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector | | | | 16b. Kind of Business/Industry Private | | | |
| | 17. Father's Name (First, Middle, Last) Willard Allen | | | | 18. Mother's Name (First, Middle, Maiden Surname) Georgia Blackwell | | | | 19a. Informant's Name/Relationship (Type, Print) Camilla Allen / Wife | | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4701 Plata Street Clinton, Maryland 20735 | | | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem. 5/11/04 | | | |
| | 20c. Location - City or Town, State Arlington, Virginia | | | | 21. Signature of Funeral Service Licensee Shirley K. Jones | | | | 22. Name and Address of Facility Alexander S. Pope Funeral Home 5538 Marlboro Pike Forestville, Maryland 20747 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic prostate cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 8 1/2 years | | | | 23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | | |
| | 23d. Date of delivery Month Day Year | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | | | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Nancy A. Dawson MD | | | | |
| 29c. License number D0031586 | | | | 29d. Date signed (Month, Day, Year) 4/28/2004 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANCY A DAWSON MD University of Maryland 22 S. Greene St Baltimore MD 21201 | | | | |
| 31. Date filed (Month, Day, Year) APR 29 2004 | | | | 32. Registrar's Signature [Signature] | | | | State Registrar | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15395

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Grace Violet Ashby

2. Date of Death

April

Day

21, 2004

3. Time of Death

10:21pM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Bradford Oaks Nursing Home

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

182-12-2858

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Nov. 28, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

307 Bucknell Circle

10f. Zip Code

20602

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

Sarah Buchanan

17. Father's Name (First, Middle, Last)

Frank Seitz

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Buchanan

19a. Informant's Name/Relationship (Type, Print)

Charles L. Ashby, III - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

307 Bucknell Circle, Waldorf, Maryland 20602

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

4/26/2004

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Ave., Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death Years

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check on one)

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

M

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19431

29d. Date signed (Month, Day, Year)

April 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank M. Ryan, M.D. 11701 Livingston Road, #103, Fort Washington, MD 20744

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

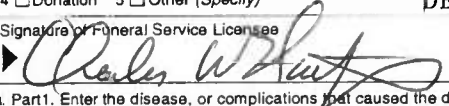
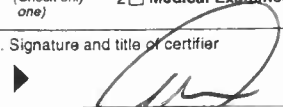
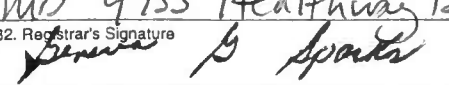
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 15396

Certificate of Death

Reg. No.

1- For
State
Registrar

| | | | | | |
|---|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALBERT WILLIAM ADAMS | | 2. Date of Death Month Day Year APRIL 20 2004 | | 3. Time of Death 2315 M |
| | 4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL | | 4b. City, Town, or Location of Death BERLIN | | 4c. County of Death WORCESTER |
| Funeral Director | 5. Social Security Number 218-14-4179 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | 8. Date of Birth (Month, Day, Year) AUG. 19, 1922 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | | | |
| To Be Completed by Funeral Director | 10a. State DELAWARE | | 10b. County SUSSEX | | 10c. City, Town or Location SELBYVILLE |
| | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number 23F LAWS POINT ROAD | | 10f. Zip Code 19975 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SPRINKLER FITTER | | 16b. Kind of Business/Industry PIPE FITTER |
| | 17. Father's Name (First, Middle, Last) HENRY ADAMS | | 18. Mother's Name (First, Middle, Maiden Surname) SARAH WROTEN | | |
| | 19a. Informant's Name/Relationship (Type, Print) JOAN D. ADAMS/WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23F LAWS POINT ROAD, SELBYVILLE, DE. 19975 | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) DELAWARE VETERANS CEM. | | 20c. Location - City or Town, State 4/26/04 MILLSBORO, DELAWARE |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Anoxic Encephalopathy Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number DS3612 | | 29d. Date signed (Month, Day, Year) 4/21/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea K. Bari, MD 9733 Healthway Dr Berlin, MD 21811 | | | | | |
| 31. Date filed (Month, Day, Year) APR 23 2004 | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15397

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Viola Anderson

2. Date of Death

Month 4 Day 26 Year 2004

3. Time of Death

10:00PM

4a. Facility Name (If not Institution, give street and number)

Ruxton Center

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

Funeral
Director

5. Social Security Number

206-12-2251

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
6-18-1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

DE

10b. County

Kent

10c. City, Town or Location

Harrington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1241 Gallo Road

10f. Zip Code

19952

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Masten Wade Hash

18. Mother's Name (First, Middle, Maiden Surname)

Coria Evaline (Ward)

19a. Informant's Name/Relationship (Type, Print)

Jerry Anderson - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 North Street Harrington, DE 19952

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Cem.
Nottingham Baptist Church

Date

4-29-04

20c. Location - City or Town, State

Nottingham, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

15522 South DuPont Hwy.
Harrington, DE 1995223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebrovascular accident

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D0047534

29d. Date signed (Month, Day, Year)

4/27/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wafik Zaki, MD 920 Market Street Denton, MD 21629

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15398

1- For State Registrar

| | | | | | | | | |
|--|---|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard Samuel Atkinson | | | | 2. Date of Death Month Day Year April 23 2004 | | 3. Time of Death 12:10 AM M | |
| | 4a. Facility Name (If not institution, give street and number) Wicomico Nursing Home | | | | 4b. City, Town, or Location of Death Salisbury | | 4c. County of Death Wicomico | |
| Funeral Director | 5. Social Security Number 216-09-6099 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 12-25-1918 | | 9. Birthplace (State or Foreign Country) Md. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | 10b. County Wicomico | 10c. City, Town or Location Salisbury | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 1734 Crestwood Circle | | | 10f. Zip Code 21804 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Servant | | | 16b. Kind of Business/Industry U.S. Navy | | |
| | 17. Father's Name (First, Middle, Last) Frank Atkinson | | | 18. Mother's Name (First, Middle, Maiden Surname) Clementine Bowen | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Susan Atwood, Daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1734 Crestwood Circle, Salisbury, Md. 21804 | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory of Delmarva 4-23-2004 | | Date 13 E. Grove St. Delmar, De. 19940 | | 20c. Location - City or Town, State Delmar, De. | |
| | 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Short Funeral Home, Inc. | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | Approximate Interval Between Onset and Death | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DEMENTIA | | | | | | | |
| To Be Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | 23d. Date of delivery Month Day Year | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | 29c. License number D55206 | | | 29d. Date signed (Month, Day, Year) APRIL 23, 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohan Bhat MD 614 Easternshore Drive Salisbury MD 21804 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 23 2004 | | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15399

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD GRANT BORING

2. Date of Death
Month Day Year
APRIL 30, 2004

3. Time of Death
8:45 PM

Funeral Director

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTHCARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

5. Social Security Number

250-66-1823

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
8/21/1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Harford

10c. City, Town or Location

Jarrettsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1710 Jarrettsville Road

10f. Zip Code

21084

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1957 1959

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12

College (1-4 or 5+) 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Maurice

18. Mother's Name (First, Middle, Maiden Surname)

Boring

Ruth

Alcesta

Strunk

19a. Informant's Name/Relationship (Type, Print)

David Saneman /Executor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1618 Morse Rd. Forest Hill, Md. 21050

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation 5/5/2004 Hampstead, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M. Bleichen Rutz

22. Name and Address of Facility

Jarrettsville, Maryland
E.G. Kurtz & Son Funeral Home, P.A.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PROSTATE CANCER

Approximate Interval Between Onset and Death
UNKNOWN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Suresh Shandelya

29c. License number

D52739

29d. Date signed (Month, Day, Year)

APRIL 30, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH SHANDELYA, M.D., VA MARYLAND HEALTHCARE SYSTEM, PERRY POINT, MD 21902

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

[Signature]

State Registrar

NAME KNOWN TO PHYSICIAN BORING, RICHARD G.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15400

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Stephen L. Bowser | | 2. Date of Death Month April Day 22 Year 2004 | | 3. Time of Death 0512 P M | |
| 4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center | | 4b. City, Town, or Location of Death Cheverly | | 4c. County of Death Prince George's | |
| 5. Social Security Number 578-80-6476 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 47 Yrs. | |
| 8. Date of Birth (Month, Day, Year) August 5, 1956 | | 9. Birthplace (State or Foreign Country) Washington, D.C. | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Oxon Hill | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 5022 Boydell Avenue | | 10f. Zip Code 20745 | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Supervisor | | 16b. Kind of Business/Industry D.C. Public Housing | | 17. Father's Name (First, Middle, Last) Ronald Bowser | |
| 18. Mother's Name (First, Middle, Maiden Surname) Barbara Swann | | 19a. Informant's Name/Relationship (Type, Print) Shadonna L. Norwood (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5022 Boydell Avenue Oxon Hill, Maryland 20745 | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park | | 20c. Location - City or Town, State Landover, Maryland | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019 | | | |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. multiple gunshot wounds Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day Year) 4/22/04 | | 28b. Time of Injury 5:00 P M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred subject shot | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 69 47th St. SE Washington D.C. | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number O.C.M.E. | |
| 29d. Date signed (Month, Day, Year) April 23, 2004 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICIA ARONICA-POLAK MO | | 31. Date filed (Month, Day, Year) APR 29 2004 | |
| 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15401

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Teresa E. Briscoe | | | | 2. Date of Death Month Day Year April 18, 2004 | | 3. Time of Death 6:55 P M | |
| 4a. Facility Name (If not institution, give street and number) Calvert County Nursing Center, Inc. | | | | 4b. City, Town, or Location of Death Prince Frederick | | 4c. County of Death Calvert | |
| 5. Social Security Number 578-38-5622 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 98 Yrs. | | 8. Date of Birth (Month, Day, Year) June 11, 1905 | |
| 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Md. | | 10b. County Calvert | | 10c. City, Town or Location St. Leonard | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number #10 Westend Blvd. | | 10f. Zip Code 20685 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk | | 16b. Kind of Business/Industry Hecht Department Store | | | |
| 17. Father's Name (First, Middle, Last) John Clark | | | | 18. Mother's Name (First, Middle, Maiden Surname) Harriet Butler | | | |
| 19a. Informant's Name/Relationship (Type, Print) Agnes Grayson (Niece) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #10 Westend Blvd. St. Leonard, Maryland 20685 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation / 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery | | Date April 23, 2004 | | 20c. Location - City or Town, State Washington, D.C. | |
| 21. Signature of Funeral Service Licensee William R. Steen | | 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. chronic renal failure Due to (or as a consequence of): b. Anemine Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. Urinary tract infection | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier D. Shah MD | | 29c. License number D 50290 | | 29d. Date signed (Month, Day, Year) 4-20-04 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Divine Shah 110, Hosp RD, Prince Frederick MD 20678 | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 29 2004 | | 32. Registrar's Signature [Signature] | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2004 15402

Reg. No.

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Lily T. Boddu

2. Date of Death

April 24, 2004

3. Time of Death

1:37 PM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

216-04-8550

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept 28, 1917

9. Birthplace (State or Foreign Country)

India

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7538 Mandan Road

10f. Zip Code

20770

10g. Citizen of What Country?

India

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: East Indian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Itty Mathews

18. Mother's Name (First, Middle, Maiden Surname)

Mary (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Queenie Armstrong (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8569 Greenbelt Road #T4, Greenbelt MD 20770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National

Date

5/1/2004

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon/Hale Funeral Home
9013 Annapolis Road, Lanham MD 20706

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):
myocardial infarction

b.

Due to (or as a consequence of):
Atherosclerotic Cardiovascular Disease

c.

Due to (or as a consequence of):
Congestive Heart Failure

d.

Due to (or as a consequence of):
COPD

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced degenerative arthritis
upper GI bleeding, peripheral
vascular disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 27902

29d. Date signed (Month, Day, Year)

4/24/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHESA CHANDRA MD

9131 Piscataway Road, Clinton MD 20735

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15403

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leo Donald Blagburn, Jr.

2. Date of Death
Month Day Year
April 23, 20043. Time of Death
2:28A MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George

5. Social Security Number

578-50-1051

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

8. Date of Birth (Month, Day, Year)

Nov. 2, 1937

9. Birthplace (State or Foreign Country)

Washington, DC.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4717 Keppler Place

10f. Zip Code

20748

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 1955
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

U.S. Postal Supervisor

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Leo D. Blagburn, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice McCall

19a. Informant's Name/Relationship (Type, Print)

Darrell L. Blagburn/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2222 Wood Duck Court; San Leandro, CA. 94579

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery April 30, 2004 Brentwood, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pope Funeral Homes
5538 Marlboro Pike
Forestville, MD. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D40324

29d. Date signed (Month, Day, Year)

APRIL, 23, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERRY JUDRIE, M.D. 7503 SURREATS ROAD, CLINTON, MARYLAND 20735

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (12) 11h

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 15404
 1- For State Registrar Amend Item 10g per informant 6839 1-21-05 tas
 Certificate of Death Reg. No.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Important: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Romeo C. Bruce | | | | 2. Date of Death Month Day Year April 21, 2004 | | 3. Time of Death 3:20 PM | |
| 4a. Facility Name (If not institution, give street and number) 12216 Wynmore Lane | | | | 4b. City, Town, or Location of Death Bowie | | 4c. County of Death Prince George's | |
| 5. Social Security Number 575-58-0785 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 72 Yrs. | 8. Date of Birth (Month, Day, Year) Mar. 14, 1932 | 9. Birthplace (State or Foreign Country) Philippines | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD. | | 10b. County Prince George's | | 10c. City, Town or Location Bowie | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 12216 Wynmore Lane | | | | 10f. Zip Code 20715 | | 10g. Citizen of What Country? Philippines USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Filipino | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professor | | 16b. Kind of Business/Industry Education | |
| 17. Father's Name (First, Middle, Last) Vicente Bruce | | | | 18. Mother's Name (First, Middle, Maiden Surname) Eufemia Cadiz | | | |
| 19a. Informant's Name/Relationship (Type, Print) Filipina Bruce / spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12216 Wynmore Lane Bowie, MD. 20715 | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crem. | | 20c. Location - City or Town, State 4-24-2004 Alexandria, VA. | | | |
| 21. Signature of Funeral Service Licensee E. Brian Powell | | | | 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 20715 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastric Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death 6 mos. | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Salvador Sylvester | | | | 29c. License number H0055927 | | 29d. Date signed (Month, Day, Year) April 23, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sylvester, M.D. 3001 Hospital Drive Cheverly, MD. | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | | | 32. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15405

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | |
|--|---|---|--------------------------|---|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard Boone Jr | | | 2. Date of Death Month Day Year 4-22-04 | | 3. Time of Death 3:40A M | |
| | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital | | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 238-46-8791 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 71 Yrs. | | 8. Date of Birth (Month, Day, Year) 12-4-32 |
| | 9. Birthplace (State or Foreign Country) North Carolina | | 10a. State Md | | 10b. County Prince George's | | 10c. City, Town or Location Ft Washington |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 6336 Rosecroft Drive | | 10f. Zip Code 20744 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | |
| 14. Race - American Indian, Black, White, etc. Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Horse Groomer | | 16b. Kind of Business/Industry Horse Racing | |
| 17. Father's Name (First, Middle, Last) Richard Boone | | 18. Mother's Name (First, Middle, Maiden Surname) Dolly McDaniels | | 19a. Informant's Name/Relationship (Type, Print) Denise L Spruill, Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 Pennsylvania Ave Mt Vernon NY 10552 | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) White Plains Rural | | Date 4-28-04 | | 20c. Location - City or Town, State White Plains NY | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility BF Taylor Funeral Services | | 1722 North Capital Street NW | | | |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia | | a. Due to (or as a consequence of): | | b. Due to (or as a consequence of): | | c. Due to (or as a consequence of): | |
| Immediate Cause (Final disease or condition resulting in death) | | d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death Unknown | | Unknown | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) | | 23d. Date of delivery Month Day Year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | 24a. Was an autopsy performed? 1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day Year) M | |
| 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number 50454 | |
| 29d. Date signed (Month, Day, Year) APR 22, 04 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Ave 3-41 Silver Spring MD 20902 | | 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature <i>[Signature]</i> | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15406

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian Belk

2. Date of Death

04 20 04

3. Time of Death

2:55 PM

4a. Facility Name (If not institution, give street and number)

St. Thomas More Nursing & Rehab. Center

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

579-12-3509

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sep. 8, 1922

9. Birthplace (State or Foreign Country)

Wash., DC

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5866 Eastern Ave., N.E.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Wallace Gray

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Jenkins

19a. Informant's Name/Relationship (Type, Print)

Joan B. Nickens - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5866 Eastern Ave., N.E. Wash., DC 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

4/26/2004

20c. Location - City or Town, State

Wash., DC

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardio Vascular disease

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

h/o CVA. Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Meer Said Zaman

29c. License number

D0022708

29d. Date signed (Month, Day, Year)

4/21/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Meer Said Zaman M.D. 1328 Southern Ave SE #307 Washington DC 20032

State
Registrar

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Meer Said Zaman

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15407

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George H. Butler

2. Date of Death
Month Day Year
April 19 20043. Time of Death
9:00 A M

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

217-36-6626

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)
March 17 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15311 Leeland Road

10f. Zip Code

20774

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

4th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Arthur Butler

18. Mother's Name (First, Middle, Maiden Surname)

Ada Butler

19a. Informant's Name/Relationship (Type, Print)

James Butler/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16100 Cambridge Court Bowie, Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Date

4/24/2004

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

K. B. Marshall

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Approximate Interval Between Onset and Death
hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acuterrenal failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier

S. B. Beck, MD

29c. License number

D 46022

29d. Date signed (Month, Day, Year)

4/19/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. B. Beck, MD 2001 Medical Parkway Annapolis, MD

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

S. B. Beck

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Rec'd. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15408

1- For State Registrar

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)

LAVANION WALLACE BELLE, SR.

2. Date of Death

April 19 2004

3. Time of Death

2300 M

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

222-01-0558

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

95 Yrs.

8. Date of Birth

Dec. 19, 1908

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Delaware

10b. County

Sussex

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

501 West 7th Street

10f. Zip Code

19956

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Laurel School District

17. Father's Name (First, Middle, Last)

Edward

18. Mother's Name (First, Middle, Maiden Surname)

Hearn

Minnie

Belle

19a. Informant's Name/Relationship (Type, Print)

Ruth Belle/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 West 7th Street - Laurel, Delaware 19956

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Zion Ch. Cemet.

Date

04/24/2004

20c. Location - City or Town, State

Laurel, Delaware

21. Signature of Funeral Service Licensee

Patricia A. Jolley

22. Name and Address of Facility

1213 Jersey Road - Salisbury, MD

JOLLEY MEMORIAL CHAPEL

21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

b. RENAL FAILURE

Due to (or as a consequence of):

c. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

d. ALZHEIMERS DEMENTIA

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. M.D.

29c. License number

057952

29d. Date signed (Month, Day, Year)

4/20/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Babulal Das, 106 Milford ST #504B, Salisbury, MD 21804

31. Date filed (Month, Day, Year)

APR 23 2004

32. Registrar's Signature

Benjamin S. Sparks

State Registrar

LAVANION WALLACE BELLE, SR.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15409

1- For State Registrar

| | | | | | | | | | | |
|--|---|--------------------------------|---|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harold G. Bentley | | | | 2. Date of Death Month April Day 19 Year 2004 | | | | 3. Time of Death 8:00 PM M | |
| | 4a. Facility Name (If not institution, give street and number) 9952 Oak Terrace | | | | 4b. City, Town, or Location of Death Mardela Springs | | | | 4c. County of Death Wicomico | |
| Funeral Director | 5. Social Security Number 288-34-2504 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) August 29, 1941 | | 9. Birthplace (State or Foreign Country) Tennessee | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Wicomico | | 10c. City, Town or Location Mardela Springs | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 9952 Oak Terrace | | | | 10f. Zip Code 21837 | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) --- | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Family Service Counselor | | | | 16b. Kind of Business/Industry Wicomico Memorial Park | | |
| 17. Father's Name (First, Middle, Last) Beecher G. Bentley | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret --- Combs | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lisa M. Lansdale (daughter) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 Moreland Drive, Franklin, Ohio 45005 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory | | Date April 22, 2004 | | 20c. Location - City or Town, State Salisbury, Maryland | | |
| 21. Signature of Funeral Service Licensee David H. Thompson | | | | 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Road, Salisbury, Maryland 21804 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPOXEMIA a. Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | |
| Approximate Interval Between Onset and Death | | | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 9 Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) 9 Unknown | | | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Dr. [Signature] | | 29c. License number 050759 | | 29d. Date signed (Month, Day, Year) 4/20/2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES O. FLASHADE 108 PINEBLUFF RD SALISBURY MD 21801 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 22 2004 | | | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15410

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Mai Betts

2. Date of Death
Month Day Year

APRIL 21, 2004

3. Time of Death

9:10a^M

4a. Facility Name (If not institution, give street and number)

Berlin Nursing & Rehab. Center

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

222-10-4430

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

8. Date of Birth (Month, Day, Year)

7-24-1918

9. Birthplace (State or Foreign Country)

De.

Usual Residence of Decedent

10a. State

Md.

10b. County

Wicomico

10c. City, Town or Location

Delmar

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

30951 E. Line Rd.

10f. Zip Code

21875

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William Frederick Mai

18. Mother's Name (First, Middle, Maiden Surname)

Lurana Owens Mai

19a. Informant's Name/Relationship (Type, Print)

Charles W. Betts, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30951 E. Line Rd. Delmar, Md. 21875

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crematory of Delmarva

Date

4-22-04

20c. Location - City or Town, State

Delmar, De.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Short Funeral Home, Inc.

13 E. Grove St. Delmar, De. 19940

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Renal Disease

Approximate Interval Between Onset and Death

Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic Cardiovascular Disease

Years

c. Due to (or as a consequence of):

Diabetes Mellitus

Years

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D28769

29d. Date signed (Month, Day, Year)

4/21/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas N. Borodulica, MD

1209 Coastal Highway
Fenwick Island, DE 19944

31. Date filed (Month, Day, Year)

APR 22 2004

32. Registrar's Signature

B Sparks

State
RegistrarBETTS, MARIE M
Baltimore, Maryland 21215-0036To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15411

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Mildred V. Carmichael | | | | 2. Date of Death Month Day Year April 20 2004 | | 3. Time of Death 8:52pm M | |
| 4a. Facility Name (If not institution, give street and number) Prince George Hospital | | | | 4b. City, Town, or Location of Death Cheverly | | 4c. County of Death Prince George | |
| 5. Social Security Number 579-26-8713 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec 18 1922 | |
| 9. Birthplace (State or Foreign Country) South Carolina | | Usual Residence of Decedent | | | | | |
| 10a. State Md | | 10b. County Prince George | | 10c. City, Town or Location CAPITOL HEIGHTS | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 819 Balsamtree Dr. | | | | 10f. Zip Code 20743 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Book Binder | | 16b. Kind of Business/Industry Gov't Printing Off. | |
| 17. Father's Name (First, Middle, Last) Jake Page | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ola Crawford | | | |
| 19a. Informant's Name/Relationship (Type, Print) Brenda J.W. Brown(daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5736 Southern Ave SE Wash, DC 20019 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cem | | 20c. Location - City or Town, State April 28, 04 Clinton Md. | |
| 21. Signature of Funeral Service Licensee <i>Tyrone J. Young</i> | | | | 22. Name and Address of Facility Tyrone J. Young Fun.Services 719 Kennedy St. NW Washington, DC 20011 | | | |

To Be Completed by Funeral Director

Physician /Medical Examiner

| | | | | | | | |
|---|--|---------------------------------------|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FATAL CARDIAC ARRHYTHMIA | | | | Approximate Interval Between Onset and Death | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | |
| 23d. Date of delivery Month Day Year | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>CHITRA VENKATRAMAN MD</i> | | | |
| 29c. License number MD D41715 | | | | 29d. Date signed (Month, Day, Year) 4-23-04 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHITRA VENKATRAMAN 6201 GREENBELT RD #U-3 COLLEGE PARK, MD 20740 | | | | | | | |

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

APR 29 2004

22. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

CR 5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15412

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MARGARET CARTER

2. Date of Death

Month Day Year
April 22 2004

3. Time of Death

1:00 AM

4a. Facility Name (If not institution, give street and number)

Larkin Chase Nursing Home

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince Georges

5. Social Security Number

267-38-0434

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
9 7 1927

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

10130 Annapolis Road

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Joseph Bolden

18. Mother's Name (First, Middle, Maiden Sumame)

Lorenza Washington

19a. Informant's Name/Relationship (Type, Print)

Lorenza Wilds/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10130 Annapolis Road Lanham, Maryland 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Long Island Nat'l Ceme

Date

4/30/04 Farmingdale, New York

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

K. D. Marshall

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending

Investigation

2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Don Yablonowitz

29c. License number

D25079

29d. Date signed (Month, Day, Year)

4/24/04

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Don Yablonowitz M.D. 7404 Executive Place # 502 Lanham, Maryland 20706

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

Don Yablonowitz

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15413

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Willie Mae Curseen

2. Date of Death

Month
AprilDay
24Year
2004

3. Time of Death

12:20 PM

4a. Facility Name (If not institution, give street and number)

Manor Care Rehab. & Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

232-56-8825

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Mar. 8, 1931

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1438 Bangor St., S.E.

10f. Zip Code

20020-4915

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

William Henderson

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Lee

19a. Informant's Name/Relationship (Type, Print)

Joseph P. Curseen, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1438 Bangor St., S.E. Wash., DC 20020-4915

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

4/29/04

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Diabetes; Hypertension; Peripheral Vascular Disease

Anoxic encephalopathy/History Cardiac Arrest

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Louise M. Stomierowski MD

29c. License number

D23588

29d. Date signed (Month, Day, Year)

April 24, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Louise M. Stomierowski, M.D. 6111 Executive Blvd., Rockville, MD 20852

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Paul A. Smith

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15414

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel B. Campbell

2. Date of Death

4/19/2004

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin, Maryland

4c. County of Death

Worcester County

Funeral
Director

5. Social Security Number

213-24-4378

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 21, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

SELBYVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

RT. 2 BOX 224B

10f. Zip Code

19975

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOHN

BRADFORD

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH

LEKITES

19a. Informant's Name/Relationship (Type, Print)

ROBERT V. CAMPBELL/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

777 SATURN DR., UNIT 101, COLORADO SPRINGS, CO 80906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

NEW HOPE CEMETERY

Date

4/23/04

20c. Location - City or Town, State

WILLARDS, MARYLAND

21. Signature of Funeral Service Licensee

Charles W. [Signature]

22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive pulmonary disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M 1 ☐ Yes 2 ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Kirstine Griffin, MD

29c. License number

C10006795

29d. Date signed (Month, Day, Year)

4-20-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KIRSTINE GRIFFIN, MD 1209 CONSTATEL HIGHWAY, FRANKLIN ISLAND, DE 19944

31. Date filed (Month, Day, Year)

APR 23 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
0000.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Ethel B. Campbell DOB 10/20/1915
213-24-4378 DOD 4/19/2004 1230

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For State Registrar

2004 15415

Physician /Medical Examiner

Funeral Director

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) MARVIN LEE CARTER JR. | | | | 2. Date of Death Month 04 Day 22 Year 2004 | | 3. Time of Death 2156 M | |
| 4a. Facility Name (If not institution, give street and number) PENINSULA Regional Medical Center | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death Wicomico | |
| 5. Social Security Number 217-24-9682 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) MAY 13, 1928 | |
| 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State DELAWARE | | 10b. County SUSSEX | | 10c. City, Town or Location SELBYVILLE | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 173 SHADY PARK | | 10f. Zip Code 19975 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DIVISION VICE PRESIDENT | | 16b. Kind of Business/Industry MANUFACTURING | | 17. Father's Name (First, Middle, Last) LYAL CARTER | |
| 18. Mother's Name (First, Middle, Maiden Surname) GLADYS HARRISON | | 19a. Informant's Name/Relationship (Type, Print) VIRGINIA S. CARTER/WIFE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 173 SHADY PARK, SELBYVILLE, DE. 19975 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) ST. JOHN'S CEMETERY | | 20c. Date 4/27/04 | | 20d. Location - City or Town, State ELLICOTT CITY, MD | | 21. Signature of Funeral Service Licensee | |
| 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARRHYTHMIA Due to (or as a consequence of): b. HYPOTENSION Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death | | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | |
| 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | |
| 29c. License number D57331 | | 29d. Date signed (Month, Day, Year) APRIL 22, 2004 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDY PIETTE, M.D. 100 E. CARROLL ST. SALISBURY MD | | 31. Date filed (Month, Day, Year) APR 26 2004 | |
| 32. Registrar's Signature | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Carter, Marvin 217 24 9682

g/VA DO

Certificate of Death

Reg. No. 2004 15416

1- For State Registrar

| | | | | | | | | | | | | |
|---|---|--|---|--|--|---|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harry Samuel Dawson | | | | 2. Date of Death Month Day Year April 25, 2004 | | | | 3. Time of Death 0610 P M | | | |
| | 4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center | | | | 4b. City, Town, or Location of Death Cheverly | | | | 4c. County of Death Prince George's | | | |
| Funeral Director | 5. Social Security Number 234-24-4787 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 81 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 21, 1923 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Temple Hills | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number 5904 Temple Hill Road | | | | 10f. Zip Code 20748 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting | | 16b. Kind of Business/Industry D.C. Transit | | | | | |
| | 17. Father's Name (First, Middle, Last) Marion O. Dawson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Roca Bohrer | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Gladys Penny Dawson - Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5904 Temple Hill Road, Temple Hills, MD 20748 | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery | | | | Date 4/29/2004 | | 20c. Location - City or Town, State Brentwood, Maryland | | | |
| | 21. Signature of Funeral Service Licensee Claudette Dasch Lanning | | | | 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): b. <i>Myocardial Infarction</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 4/25/04 | | 28b. Time of Injury 12:29 P M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred <i>Subject was struck by vehicle</i> | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>roadway</i> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>at Eastern Highway, Prince George's</i> | | 29b. Signature and title of certifier <i>Theodore M. McKenney</i> | | 29c. License number O.C.M.E. | | | | |
| 29d. Date signed (Month, Day, Year) April 26, 2004 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>THEODORE MCKENNEY</i> 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year) APR 29 2004 | | 32. Registrar's Signature <i>Heidi K. Spiller</i> | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 15417

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last) VERNA DUNHAM | | 2. Date of Death Month April Day 21 Year 2004 | | 3. Time of Death 10:00 p^M | |
| 4a. Facility Name (If not institution, give street and number) 5011 Edmonston Road | | 4b. City, Town, or Location of Death Hyattsville | | 4c. County of Death Prince George's | |
| 5. Social Security Number 577-18-3587 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | 8. Date of Birth (Month, Day, Year) March 25, 1919 | 9. Birthplace (State or Foreign Country) Kentucky |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Prince George's | 10c. City, Town or Location Hyattsville | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 5011 Edmonston Road | | 10f. Zip Code 20781 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) Chester Bright | | 18. Mother's Name (First, Middle, Maiden Surname) Kate Jackson | | | |
| 19a. Informant's Name/Relationship (Type, Print) Russell D. Dunham - Spouse | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5011 Edmonston Road, Hyattsville, Maryland 20781 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery | | 20c. Location - City or Town, State 4/26/2004 Brentwood, Maryland | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cardiac Arrhythmia Due to (or as a consequence of): b. Coronary Disease w/ Cardiomyopathy Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D-0018852 | | 29d. Date signed (Month, Day, Year) April 22, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chuntung Changchien, M.D. 8824 Cunningham Drive, Suite D, Berwyn Heights, MD 20740 | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature  | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15418

1- For
State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 503-693-5000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|---|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) NYLSA | | 2. Date of Death Month Day Year APRIL 22 2004 | | 3. Time of Death 2:34 PM | |
| 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 096-48-8258 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 49 Yrs. | 8. Date of Birth (Month, Day, Year) 08-20-1954 | 9. Birthplace (State or Foreign Country) PUERTO RICO | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County WICOMICO | 10c. City, Town or Location SALISBURY | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 608 HAMMOND STREET | | 10f. Zip Code 21804 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: PUERTO RICAN | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | |
| 16b. Kind of Business/Industry OWN HOME | | 17. Father's Name (First, Middle, Last) CRUZ FERNANDEZ | | 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN SANCHEZ | |
| 19a. Informant's Name/Relationship (Type, Print) JORGE DeJESUS - SPOUSE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 HAMMOND STREET, SALISBURY, MARYLAND 21804 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) PARSONS CEMETERY | | 20c. Location - City or Town, State 04-28-2004 SALISBURY, MARYLAND | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DILATED CARDIOMYOPATHY Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 YEARS | | | | | |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | | | | |
| 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) | | | | | |
| 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> MD | | 29c. License number RES - 000 | | 29d. Date signed (Month, Day, Year) APRIL 22 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASIHAR SAFAR 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21207 | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

State
Registrar

Page Not Found

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15420

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|--|---|---|---------------------------------|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elmer Dale Eby | | | 2. Date of Death Month Day Year April 22, 2004 | | | 3. Time of Death 8:00 AM | | | |
| | 4a. Facility Name (If not institution, give street and number) 1015 Tyler Avenue | | | 4b. City, Town, or Location of Death Salisbury | | | 4c. County of Death Wicomico | | | |
| Funeral Director | 5. Social Security Number 334-34-3846 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 64 Yrs. | | 8. Date of Birth (Month, Day, Year) August 14, 1939 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | 10a. State Maryland | | | 10b. County Wicomico | | | 10c. City, Town or Location Salisbury | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| To Be Completed by Funeral Director | 10e. Street and Number 1015 Tyler Avenue | | | 10f. Zip Code 21804 | | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Coast Guard | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse | | | 16b. Kind of Business/Industry Healthcare | | | |
| | 17. Father's Name (First, Middle, Last) Paul Raymond Eby | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elsie Alberta Yoder | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Elsie Deana Taylor (sister) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14252 Backbone Road, Eden, Maryland 21822 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory | | | 20c. Location - City or Town, State April 23, 2004 Salisbury, Maryland | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee | | | 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Road, Salisbury, Maryland 21804 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ascid a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | |
| State Registrar | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) | | | 23d. Date of delivery Month Day Year | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Hypertension | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier | | | 29c. License number H50457 | | 29d. Date signed (Month, Day, Year) 4/23/04 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chris Snyder D.O. 100 E. Carroll St. Salisbury MD 21801 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) APR 23 2004 | | | 32. Registrar's Signature | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15421

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie Rosalee Horsey Ennis

2. Date of Death

Month

Day

Year

3. Time of Death

1200

M

4a. Facility Name (If not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

219-05-3540

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

Jan. 28 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Hebron

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7941 Belle Avenue

10f. Zip Code

21830

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Granville Horsey Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Gale

19a. Informant's Name/Relationship (Type, Print)

William F. Ennis (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7941 Belle Ave. Hebron, Md. 21830

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Springhill Mem. Garden

Date

4/24/04

20c. Location - City or Town, State

Hebron, Md.

21. Signature of Funeral Service Licensee

Bladys B. Stewart

22. Name and Address of Facility

Stewart Funeral Home
821 West Rd. Salisbury, Md. 2180123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Massive stroke

a. Due to (or as a consequence of):

cerebral atherosclerosis

b. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① Acute MI
② DM
③ Renal Failure

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Bladys B. Stewart

29c. License number

D25036

29d. Date signed (Month, Day, Year)

4/21/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H.R. HEDRA

614 EASTERN SHORE DRIVE - SALISBURY - MD
21804

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15422

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Theodore Fawks, Jr.

2. Date of Death

Month Day Year April 29 2004 18:04 P M

3. Time of Death

18:04 P M

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

209-20-1658

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year Oct 22, 1927

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

PA

10b. County

Franklin

10c. City, Town or Location

Waynesboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14066 Wayne Highway

10f. Zip Code

17268

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Soldier

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Charles T. Fawks, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Feathers

19a. Informant's Name/Relationship (Type, Print)

Lucille M. Fawks wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14066 Wayne Highway Waynesboro, PA 17268

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Andrew Cemetery May 4, 2004 Waynesboro, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Janette M. Felmer

22. Name and Address of Facility

Grove-Bowersox Funeral Home, Inc.
50 S Broad ST Waynesboro, PA 17268

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe chronic obstructive pulmonary disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death
years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia
Renal Failure

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Allen MD

29c. License number

B 41786

29d. Date signed (Month, Day, Year)

5/3/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Allen MD, 12821 Oak Hill Lane, Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15423

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lawrence Falcone

2. Date of Death

Month Day Year
April 24, 2004

3. Time of Death

10:15 a M

4a. Facility Name (If not institution, give street and number)

6107 40th Avenue

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

5. Social Security Number

141-01-7452

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 10, 1916

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6107 40th Avenue

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1942-

If Yes, Give Year or Dates: 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Mailer

16b. Kind of Business/Industry

Newspaper

17. Father's Name (First, Middle, Last)

Philip Falcone

18. Mother's Name (First, Middle, Maiden Sumame)

Mary Confalone

19a. Informant's Name/Relationship (Type, Print)

Mary Scaldaferrri -- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14603 Baugher Drive, Centreville, VA 20120

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

04/27/2004

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Claudette Dock Lanning

22. Name and Address of Facility

Gasch's Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death
Few Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory Failure

Due to (or as a consequence of):

Months

c. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Years

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer

Heart Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check on one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rashid Baghai

29c. License number

D39372

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rashid Baghai, M.D., 344 University Blvd., West, Ste. 324, Silver Spring, MD 20901

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Rashid Baghai

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar


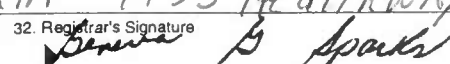
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15424

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

| | | | | |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) MARY AVIS FITZE | | 2. Date of Death Month 4 Day 20 Year 2004 | | 3. Time of Death 6:45 A.M. |
| 4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL | | 4b. City, Town, or Location of Death BERLIN | | 4c. County of Death WORCESTER |
| 5. Social Security Number 220-05-0889 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | 8. Date of Birth (Month, Day, Year) JAN. 17, 1922 | 9. Birthplace (State or Foreign Country) VIRGINIA |
| Usual Residence of Decedent | | | | |
| 10a. State DELAWARE | 10b. County SUSSEX | 10c. City, Town or Location SELBYVILLE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 20B BLUE TEAL ROAD | | 10f. Zip Code 19975 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) SEAMSTRESS | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLOTHING | | 16b. Kind of Business/Industry | | |
| 17. Father's Name (First, Middle, Last) ROBERT L. HOSIER SR. | | 18. Mother's Name (First, Middle, Maiden Surname) MARY E. ANGEL | | |
| 19a. Informant's Name/Relationship (Type, Print) CHARLES O. FITZE / HUSBAND | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20B BLUE TEAL RD., SELBYVILLE, DE. 19975 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CREMATORY OF DELMARVA | | 20c. Location - City or Town, State 4/21/04 DELMAR, DELAWARE |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventricular Arrhythmia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 3 days |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) M | | 28b. Time of Injury 1 Yes <input checked="" type="checkbox"/> No |
| 28c. Describe how injury occurred | | 28d. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number 444283 |
| 29d. Date signed (Month, Day, Year) 4/22/04 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Ducken 9733 Heathway Drive Berlin MD 21811 | | |
| 31. Date filed (Month, Day, Year) APR 23 2004 | | 32. Registrar's Signature  | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15425

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

| | | | | | |
|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Willie Mae Gantt | | 2. Date of Death Month April Day 27 Year 2004 | | 3. Time of Death 11:55A M | |
| 4a. Facility Name (If not institution, give street and number) Prince George Hospital | | 4b. City, Town, or Location of Death Cheverly | | 4c. County of Death Prince George | |
| 5. Social Security Number 247-56-4973 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 4, 1914 |
| 9. Birthplace (State or Foreign Country) South Carolina | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Prince George | 10c. City, Town or Location Cheverly | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 2900 Mercy Lane | | 10f. Zip Code 20785 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Environmental Servicer | | 16b. Kind of Business/Industry Federal Government | |
| 17. Father's Name (First, Middle, Last) Jake Glenn | | 18. Mother's Name (First, Middle, Maiden Surname) Lula Jennings | | | |
| 19a. Informant's Name/Relationship (Type, Print) Grover Gantt/Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6103 Addison Road; Seat Pleasant, MD. 20743 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park | | 20c. Location - City or Town, State Landover, MD. | |
| 21. Signature of Funeral Service Licensee <i>Keith A. Savage M.D.</i> | | 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death years | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SIRS Stage IV Ischemic Foot Ulcer (left) Hypercoagulability Cerebral Thrombosis | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier <i>Paul A. DeVore MD</i> | | 29c. License number DO1852 | | 29d. Date signed (Month, Day, Year) April 27 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. DeVore MD 4203 Queensbury Rd Hyattsville MD 20781 | | | | | |
| 31. Date filed (Month, Day, Year) APR 29 2004 | | 32. Registrar's Signature <i>John K. Smith</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15426

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Taft Green, Jr.

2. Date of Death

Month

Day

Year

APRIL

28

2004

3. Time of Death

8:40 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-56-1104

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
July 6, 1943

9. Birthplace (State or Foreign Country)

Wash., DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Mt. Rainier

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3307 Chauncey Pl., #102

10f. Zip Code

20712

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married☒ Married☐ Widowed☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Engineer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Taft Green, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Harris

19a. Informant's Name/Relationship (Type, Print)

Ramona Green - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3307 Chauncey Pl., #102, Mt. Rainier, MD 20712

20a. Method of Disposition

☒ Burial☐ Cremation☐ Removal from State☐ Donation☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glenwood Cemetery

Date

4/29/2004

20c. Location - City or Town, State

Wash., DC

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

b. METASTATIC ESOPHAGEAL CANCER

Due to (or as a consequence of):

c. ESOPHAGEAL CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DECEMBER 03

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Pending investigation☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Inspector

29c. License number

D19971

29d. Date signed (Month, Day, Year)

04/22/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. SUDHAKAR MD 7610 CARROLL AVE #230 TAKOMA PARK MD 20912

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

K. Sudhakar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15427

1- For
State
Registrar

| | | | | | | | | |
|---|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Fannie Gholson | | | | 2. Date of Death Month Day Year April 16 2004 | | 3. Time of Death 9:00 a m | |
| | 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death Takoma Park | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 579-44-9166 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 95 Yrs. | | 8. Date of Birth (Month, Day, Year) 08-02-1908 | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 901 Alcola Avenue | | 10f. Zip Code 20902 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Funeral Director | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Licensed Practical Nurse | | 16b. Kind of Business/Industry Private | | | |
| | 17. Father's Name (First, Middle, Last) Robert Washington | | 18. Mother's Name (First, Middle, Maiden Surname) Josephine Howard | | 19a. Informant's Name/Relationship (Type, Print) William McIntosh/ Nephew | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2102 Hannon St., Hyattsville, MD 20783 | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Washington Nat'l Cem. | | Date 04/21/2004 | | 20c. Location - City or Town, State Suitland, Maryland | |
| | 21. Signature of Funeral Service Licensee <i>Beha J. Jenkins</i> | | 22. Name and Address of Facility Johnson & Jenkins F.H. 716 Kennedy St., Washington DC. 20011 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>SEPSIS</u> Due to (or as a consequence of): b. <u>Renal Failure</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 24 HRS 1 week | | | |
| To Be Completed by Physician/Medical Examiner | 23b. If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Tom P. Kannarakat MD.</i> | |
| To Be Completed by Physician/Medical Examiner | 29c. License number D-20062 | | 29d. Date signed (Month, Day, Year) April 16 th , 2004 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tony P. KANNARAKAT MD 8201 16 th St. SILVER SPRING, MARYLAND 20910 | | 31. Date filed (Month, Day, Year) APR 27 2004 | |
| | 32. Registrar's Signature <i>Arden K. Spiller</i> | | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15428

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Goodman

2. Date of Death

Month Day Year
April 22, 2004

3. Time of Death

7:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Clinton Nursing Rehab. Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

225-74-1459

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jul 13, 1951

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Cheltenham

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10505 Jib Court

10f. Zip Code

20623

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Phone Technician

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Gilbert R. Goodman

18. Mother's Name (First, Middle, Maiden Surname)

Revera A. Wilson

19a. Informant's Name/Relationship (Type, Print)

Tonnette Goodman - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10505 Jib Court; Cheltenham, Maryland 20623

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Mem Gardens

Date

4/30/2004

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

Robert O. Freeman

22. Name and Address of Facility

Robert O. Freeman Funeral Services, inc.
1353 H Street, N.E. Washington, DC 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of Kidney with Extensive Metastasis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death
☐ Pregnant at time of death ☐ Ectopic pregnancy
☐ Unknown ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy performed?
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No26. Place of Death (Check only one)
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert O. Freeman

29c. License number

1 51520

29d. Date signed (Month, Day, Year)

4-26-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bahram Pishdad, MD 1328 Southern Avenue, SE Rm#310 Washington, DC 20032

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Robert O. Freeman

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

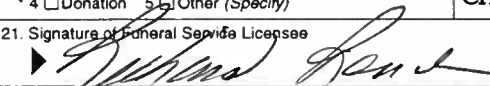
Reg. No.

2004 15429

1- For State Registrar

Physician /Medical Examiner


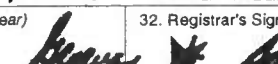
Funeral Director

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Jewel T. Gardner | | | | 2. Date of Death Month April Day 23 Year 2004 | | 3. Time of Death 8:15 A M | |
| 4a. Facility Name (If not institution, give street and number) 9209 3rd Street | | | | 4b. City, Town, or Location of Death Lanham | | 4c. County of Death Prince George's | |
| 5. Social Security Number 578-54-0729 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct 6, 1923 | |
| 9. Birthplace (State or Foreign Country) Washington DC | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Lanham | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 9209 3rd Street | | 10f. Zip Code 20706 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Private | | 17. Father's Name (First, Middle, Last) Nathaniel Hills | |
| 18. Mother's Name (First, Middle, Maiden Surname) Lillian Lightfoot | | 19a. Informant's Name/Relationship (Type, Print) Belita Willoughby (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9209 3rd Street, Lanham MD 20706 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | Date 4/24/2004 | | 20c. Location - City or Town, State Beltsville, MD | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 | | | | | |

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

| | | | | | |
|--|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia | | | | Approximate Interval Between Onset and Death | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (List one of 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000) | | | | | |
| 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | |
| 23d. Date of delivery Month _____ Day _____ Year _____ | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M _____ | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D045881 | | 29d. Date signed (Month, Day, Year) April 23, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carl Johnson, M.D. 1221 Mercantile Lane, Upper Marlboro, MD 20774-5374 | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature  | | | |

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15430

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David N. Harris, Sr.

2. Date of Death

Month Day Year
April 9, 2004

3. Time of Death

11:56 M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

577-64-4227

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

July 18, 1948

9. Birthplace (State or Foreign Country)

Wash., DC

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4411 - 5th St., N.W.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Engineer

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Charles Harris

18. Mother's Name (First, Middle, Maiden Surname)

Geneva Dillard

19a. Informant's Name/Relationship (Type, Print)

Mary T. Harris - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4411 - 5th St., N.W. Wash., DC 20011

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee's Crematory

Date

4/21/2004

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Salvador S. Synter, MD

29c. License number

H0058927

29d. Date signed (Month, Day, Year)

April 14, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador S. Synter, 3001 Hospital Drive, Cheverly, Maryland

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

John T. Stewart III

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15431

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JoAnn S. Hill | | | | 2. Date of Death Month Day Year 04 26 2004 | | | | 3. Time of Death 03:45 A M | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Casey House | | | | 4b. City, Town, or Location of Death Rockville | | | | 4c. County of Death Montgomery | | | | | | |
| Funeral Director | 5. Social Security Number 578-52-1660 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) 01 02 38 | | 9. Birthplace (State or Foreign Country) Washington, D.C. | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| 10a. State D.C. | | 10b. County | | 10c. City, Town or Location Washington | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 10e. Street and Number 1406 Delafield Place N.W. | | | | 10f. Zip Code 20011 | | | | 10g. Citizen of What Country? USA | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs. | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse | | | | 16b. Kind of Business/Industry Children's Hospital | | | | | | | |
| 17. Father's Name (First, Middle, Last) Harold L. Scott | | | | 18. Mother's Name (First, Middle, Maiden Surname) Dora Henderson | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Joseph E. Hill, Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 Delafield Pl. N.W. Washington, D.C. 20011 | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek | | 20c. Date 5-3-04 | | 20d. Location - City or Town, State Washington, D.C. | | | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011 | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End Stage Hepatic Cirrhosis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death 6 months. | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier  | | 29c. License number 00041218 | | 29d. Date signed (Month, Day, Year) 4/26/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison 6001 Muncaster Mill Road, Rockville, MD. 20855 | | | | | | | | | | 31. Date filed (Month, Day, Year) APR 29 2004 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15432

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Harvey

2. Date of Death

Month Day Year
April 26, 2004

3. Time of Death

5:20 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Layhill Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

242-14-4820

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 17, 1919

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6537 North Capital Street, NE

10f. Zip Code

20012

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Mark Harvey

18. Mother's Name (First, Middle, Maiden Surname)

Martha Arrington

19a. Informant's Name/Relationship (Type, Print)

Cleora Knight-Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6537 N. Capital St., NE, Washington, D.C. 20012

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Quantico National

Date

05-04-2004

20c. Location - City or Town, State

Triangle, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fort Lincoln Funeral Home

3401 Bladensburg Rd., Brentwood, MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Parkinson's Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D38262

29d. Date signed (Month, Day, Year)

April 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anurita Mendiratta, M.D. 2401 Research Blvd., #330, Rockville, MD 20850

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15433

1- For State Registrar

Physician / Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last) James W. Henson 2. Date of Death Month Day Year April 22, 2004 3. Time of Death 8:30 A M

4a. Facility Name (If not institution, give street and number) 2504 Ramblewood Drive 4b. City, Town, or Location of Death District Heights 4c. County of Death Prince Georges

5. Social Security Number 324-14-4938 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 87 Yrs. 8. Date of Birth (Month, Day, Year) March 14, 1917 9. Birthplace (State or Foreign Country) Illinois

Usual Residence of Decedent 10a. State Maryland 10b. County Prince Georges 10c. City, Town or Location District Heights 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 2504 Ramblewood Drive 10f. Zip Code 20747 10g. Citizen of What Country? USA

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Budget/Finance Analyst 16b. Kind of Business/Industry Federal Government

17. Father's Name (First, Middle, Last) Earl Henson 18. Mother's Name (First, Middle, Maiden Surname) Lola Dorriess

19a. Informant's Name/Relationship (Type, Print) Anita L. Henson / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2504 Ramblewood Dr., Distict Heights, MD 20747

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery 4/26/04 20c. Location - City or Town, State Clinton, MD

21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RADIATION COLITIS WITH FISTULA 1 YEAR

Due to (or as a consequence of): CANCER OF THE BLADDER 1 YEAR

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number D-18545 29d. Date signed (Month, Day, Year) APRIL 23, 2004

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) Philip Wisotsky M.D. 12070 Old Line Center # 207 Waldorf, Maryland 20602

31. Date filed (Month, Day, Year) APR 27 2004 32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15434

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Herman Lyle Hanna

2. Date of Death

April 21, 2004

3. Time of Death

7:00 a M

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

577-03-2108

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 12, 1908

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8673 Greenbelt Road, Apt. 102

10f. Zip Code

20770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No 1925-
If Yes, Give
Year or Dates: 192913. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Aircraft Motor Mechanic

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

David A. Hanna

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Patterson

19a. Informant's Name/Relationship (Type, Print)

Roy A. Hammond - Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

70 Frazer Road, Garrison, NY 10524

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

04/26/2004

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Claudette Dooch Lanning

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Sepsis
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. PNEUMONIA
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Days

Days

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Paul A. Devore

29c. License number

101852

29d. Date signed (Month, Day, Year)

APRIL 23 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL A. DEVORE MD 4203 GREENSBURY RD HYATTSVILLE MD 20781

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Paul A. Devore

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **AMEND ITEM #3 PER PHY G831 5/13/04** **Certificate of Death**

Reg. No.

2004 15435

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Richard Glen Harnish

2. Date of Death

Month Day Year
March 9 2004

3. Time of Death

8:00am M

4a. Facility Name (If not institution, give street and number)

840 A Northern Ave.

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

216-22-7642

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 24, 1929

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

840 A Northern Ave.

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married

☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No 1948

If Yes, Give Year or Dates: 1951

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chiropractor

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Wilbur Glen Harnish

18. Mother's Name (First, Middle, Maiden Surname)

Noll Light

19a. Informant's Name/Relationship (Type, Print)

Doris J. Harnish/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

840 A Northern Ave. Hagerstown, MD 21742

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

3/11/2004

20c. Location - City or Town, State

Hagerstown, MD

21. Signature of Funeral Service Licensee

Stephen M. Sings

22. Name and Address of Facility

Rest Haven Funeral Chapel
1601 Pennsylvania Ave. Hagerstown, MD 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

myocardial infarction

chronic coronary artery disease

Approximate Interval Between Onset and Death

HRS

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No

☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death

☐ Pregnant at time of death

☐ Unknown

☐ Ectopic pregnancy

☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician

☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John M. Wood

29c. License number

D0011466

29d. Date signed (Month, Day, Year)

March 10, 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. N. Wood M.D. 580 Northern Ave Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

MAR 10 2004

32. Registrar's Signature

Sharon B. Sparks

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, Wash #3

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar amended 4-23-04 item #8 with Certificate of Death

Reg. No. 2004 15436

Physician /Medical Examiner
Funeral Director

| | | | | |
|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last) Charles Edward Harmon | | 2. Date of Death Month April Day 9 Year 2004 | | 3. Time of Death 6:30 AM |
| 4a. Facility Name (If not institution, give street and number) 10541 Flower Street | | 4b. City, Town, or Location of Death Berlin | | 4c. County of Death Worcester |
| 5. Social Security Number 216 - 44-8429 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 47 Yrs. | 8. Date of Birth (Month, Day, Year) March 26, 1957 | 9. Birthplace (State or Foreign Country) Maryland |

| | | | | |
|---|---------------------------------|--|--|--|
| Usual Residence of Decedent | | 10c. City, Town or Location Berlin | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10a. State Maryland | 10b. County Worcester | 10e. Street and Number 10541 Flower Street | | 10f. Zip Code 21811 |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | |

| | | | | |
|--|--|--|--|---|
| 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 14. Race - American Indian, Black, White, etc. Specify: Black |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) self-employed | | 16b. Kind of Business/Industry Autobody and Repair |

| | | | | |
|---|--|---|--|--|
| 17. Father's Name (First, Middle, Last) Brazille Briddell | | 18. Mother's Name (First, Middle, Maiden Sumame) Pearl Maree Harmon | | |
|---|--|---|--|--|

| | | | | |
|--|--|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print) Tammy Harmon/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 108 - Berlin, Maryland 21811 | | |
|--|--|--|--|--|

| | | | | |
|---|--|---|--|--|
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul Church Cem. | | 20c. Location - City or Town, State Berlin, Maryland |
|---|--|---|--|--|

| | | | | |
|---|--|---|--|--|
| 21. Signature of Funeral Service Licensee <i>Patricia Jolley</i> | | 22. Name and Address of Facility Jolley Memorial Chapel 21801 | | |
|---|--|---|--|--|

| | | |
|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gastrointestinal bleeding | | Approximate Interval Between Onset and Death 2 weeks |
|--|--|--|

| | | |
|---|--|------------------|
| Due to (or as a consequence of): Duodenal carcinoma | | 10 months |
|---|--|------------------|

| | | |
|----------------------------------|--|--|
| Due to (or as a consequence of): | | |
|----------------------------------|--|--|

| | | |
|----------------------------------|--|--|
| Due to (or as a consequence of): | | |
|----------------------------------|--|--|

| | | | |
|--|--|---|---|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) | 23d. Date of delivery Month Day Year |
|--|--|---|---|

| | | | |
|---|--|---|--|
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
|---|--|---|--|

| | | | | | | |
|---|--|---------------------------------------|--|---------------------------------|---|-----------------------------------|
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
|---|--|---------------------------------------|--|---------------------------------|---|-----------------------------------|

| | | | | |
|--|--|--|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
|--|--|--|--|--|

| | | | | | |
|---|--|---|--|---------------------------------------|---|
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Rosalyn Juergens MD</i> | | 29c. License number D 60203 | 29d. Date signed (Month, Day, Year) April 9, 2004 |
|---|--|---|--|---------------------------------------|---|

| | | | |
|--|--|---|---|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rosalyn Juergens MD 1650 Orleans Street Johns Hopkins CRB-186 Baltimore, Maryland | | 31. Date filed (Month, Day, Year) APR 23 2004 | 32. Registrar's Signature <i>[Signature]</i> |
|--|--|---|---|

To Be Completed by Funeral Director

Physician /Medical Examiner

To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15437

1- For
State
Registrar

| | | | | | | | | | | | | |
|--|---|--|---|--|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Grace Elizabeth Hamstra | | | | 2. Date of Death Month April Day 22 Year 2004 | | | | 3. Time of Death 7:05 PM^M | | | |
| | 4a. Facility Name (If not institution, give street and number) 1137 Riverside Drive | | | | 4b. City, Town, or Location of Death Salisbury | | | | 4c. County of Death Wicomico | | | |
| Funeral Director | 5. Social Security Number 350-07-2632 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) August 20, 1916 | | 9. Birthplace (State or Foreign Country) Minnesota | | | |
| | 10a. State Maryland | | | | 10b. County Wicomico | | 10c. City, Town or Location Salisbury | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10e. Street and Number 1137 Riverside Drive | | | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? USA | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Manager | | 16b. Kind of Business/Industry Investment Banking | | | | | | | |
| | 17. Father's Name (First, Middle, Last) John --- Metz | | | | 18. Mother's Name (First, Middle, Maiden Surname) Grace --- Bradley | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) J. Howard Hamstra (husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1137 Riverside Drive, Salisbury, Maryland 21801 | | | | | | | |
| Physician /Medical Examiner | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory | | Date April 24, 2004 | | 20c. Location - City or Town, State Salisbury, Maryland | | | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Road, Salisbury, Maryland 21804 | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Arrest Due to (or as a consequence of): b. Coronary Heart Failure Due to (or as a consequence of): c. ASCVD Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death MIN MTHS YRS | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. AORTIC STENOSIS | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D10688 | | 29d. Date signed (Month, Day, Year) 4/23/04 | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald H. Wood, MD 400 Eastern Shore Drive, Salisbury, Md 21804 | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) APR 23 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

500

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15438

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rodger Darnel Jenkins

2. Date of Death
Month Day Year
April 25, 2004

3. Time of Death
0700 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

University - Shock Trauma Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

157-68-6045

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

32 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11-25-1971

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

218 South Payson Street

10f. Zip Code

20853

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Forklifter

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Eric Asbey Jenkins

18. Mother's Name (First, Middle, Maiden Surname)

Joan Lee Johnson

19a. Informant's Name/Relationship (Type, Print)

Tamelle Louise Jenkins/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9706 Locust Avenue
Lanham, Maryland, 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cem.

05-01-04

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Wanda C. Bacon, CC 361

22. Name and Address of Facility

W.H. Bacon Funeral Home, Inc.
3447 14th St., N.W. Wash., D.C. 20010

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Head and Neck Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Shock Trauma

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

4/25/04

28b. Time of Injury

unknown M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

roadway

28d. Describe how injury occurred

Subject driver of vehicle in vehicle accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

211 State St. near
EX of 44, Baltimore County, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Theodore H. King

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. KING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 29 2004

32. Registrar's Signature

Heidi K. Spivey

State Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CP (20)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15439

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS ODELL JOHNSON, JR.

2. Date of Death

Month Day Year
APRIL 22, 2004

3. Time of Death

11:15a M

4a. Facility Name (If not institution, give street and number)

Hospice of Chesapeake

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundle

5. Social Security Number

237-44-4349

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10-09-1933

9. Birthplace (State or Foreign Country)

CHARLOTTE, NC

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5217 Central Ave SE

10f. Zip Code

20019

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Grocery Clerk

16b. Kind of Business/Industry

Giant

17. Father's Name (First, Middle, Last)

Thomas Odell Johnson Sr

18. Mother's Name (First, Middle, Maiden Surname)

Mayo Westmoreland

19a. Informant's Name/Relationship (Type, Print)

Curtis Johnson, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10305 Musket Crt Ft Washington Md 20744

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Cemetery

Date

5-1-04

20c. Location - City or Town, State

Landover, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

B.F. TAYLOR FUNERAL SERVICE

1722 NORTH CAPITOL ST., NW WASHINGTON, DC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Head & Neck Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death
☐ Pregnant at time of death ☐ Unknown☐ Ectopic pregnancy
☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy performed?
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) Hospice

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D23743

29d. Date signed (Month, Day, Year)

4-23-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin Weltz D. O. FACP 7525 Greenway Center Dr #205 Greenbelt Md 20770

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For
State
Registrar

Reg. No. 2004 15440

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES EDWARD PILGRIM JUPITER

2. Date of Death

Month Day Year
APRIL 23, 2004

3. Time of Death

3:00 pM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

578-36-4977

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 12 1924

9. Birthplace (State or Foreign Country)

Guyana

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10951 Amherst Avenue

10f. Zip Code

20902

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)
8years16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Dentist

16b. Kind of Business/Industry

Denistry

17. Father's Name (First, Middle, Last)

Eleazer Jupiter

18. Mother's Name (First, Middle, Maiden Surname)

Francis Pilgrim

19a. Informant's Name/Relationship (Type, Print)

Michael Jupiter / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10945 Amherst Ave. Wheaton, Md. 20902

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

4-30-04

20c. Location - City or Town, State

Beltsville, Md.

21. Signature of Funeral Service Licensee

Charon Johnson-Jalley

22. Name and Address of Facility

Capitol Mortuary, Inc.

1425 Maryland Ave., N.E. Wash., DC 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. VENTRICULAR ARRHYTHMIA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

ALZHEIMER'S DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shashank Patel

29c. License number

D0058962

29d. Date signed (Month, Day, Year)

April 24, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shashank Patel, M.D. 2309 Shorefield Road Wheaton, Md. 20902

State
Registrar

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

Shashank Patel

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15441

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edith Jones Josey

2. Date of Death

Month Day Year
April 24 2004

3. Time of Death

5:05 PM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

225-46-5529

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 20, 1937

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4204 E. Capitol St., S.E. #203

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Bureau of Indian Affairs/Dept. of Int.

17. Father's Name (First, Middle, Last)

Thomas Emmitt Jones

18. Mother's Name (First, Middle, Maiden Surname)

Edith Pollard

19a. Informant's Name/Relationship (Type, Print)

Adrienne B. Sisco - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3600 Mystic Valley Pwy., #W911, Medford, MA 02155

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park 4/30/04

Date

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

John T. Stewart, III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Massive Intracranial Hemorrhage

Approximate Interval Between Onset and Death

hours

b. Due to (or as a consequence of):

Hypertensive Emergency

Days

c. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Failure
Diabetes Mellitus
Rhabdomyolysis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Figaro, M.D.

29c. License number

D0052865

29d. Date signed (Month, Day, Year)

April 24th 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Figaro, M.D. 3001 Hospital Dr., Cheverly, MD 20785

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

1- For
State
Registrar

2004 15442

| | | | | | | | | |
|--|--|---|---|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LEON O. JACKSON JR. | | | | 2. Date of Death Month Day Year APRIL 26 2004 | | 3. Time of Death 1:05 P M | |
| | 4a. Facility Name (If not institution, give street and number) GLADYS SPELLMAN SPECIALITY HOSPITAL | | | | 4b. City, Town, or Location of Death CHEVERLY | | 4c. County of Death PRINCE GEORGE'S | |
| Funeral Director | 5. Social Security Number 579-36-0599 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 74 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 11 01 1929 | | 9. Birthplace (State or Foreign Country) Washington, DC |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Prince George's | | 10c. City, Town or Location Landover | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 1500 Brightseat Rd # 101 | | | 10f. Zip Code 20785 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer | | | 16b. Kind of Business/Industry Government | | |
| | 17. Father's Name (First, Middle, Last) Leon O. Jackson Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Geneva Forrester | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Geneva Gray/ Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8502 Magnolia Drive Lanham, Maryland 20706 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Cemetery | | Date 5/4/2004 | | 20c. Location - City or Town, State Landover, Maryland | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC (CARDIOVASCULAR) DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 4 years | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | | 3 <input type="checkbox"/> Ectopic pregnancy 5 <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis Carcinoma larynx Cerebral thrombosis | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number DO1852 | | 29d. Date signed (Month, Day, Year) APRIL 26 2004 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Devor 3001 Hospital Dr. Cheverly Md. 20785 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15443

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Maria Johnson

2. Date of Death

04 14 2004

3. Time of Death

8:00 pm

4a. Facility Name (If not institution, give street and number)

St. Thomas Moore Nursing Home

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

578-46-7296

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 25, 1919

9. Birthplace (State or Foreign Country)

South Carolina

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

909 Lawrence St., N.E.

10f. Zip Code

20017

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

lyr

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Practical Nurse

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John Elisha Croker

18. Mother's Name (First, Middle, Maiden Surname)

Annie Floyd

19a. Informant's Name/Relationship (Type, Print)

Douglas F. Johnson/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

909 Lawrence St., N.E. Wash. D.C. 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate Of Heaven Cem.

Date

4/20/04

20c. Location - City or Town, State

Silver Spring, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Johnson & Jenkins Inc.

716 Kennedy St., N.W. Wash. D.C. 20011

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC HEART DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, DIABETES MELLITUS,

END STAGE RENAL DISEASE, CORONARY

ARTERY DISEASE, PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

N/A

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Doris Bustos

29c. License number

D0058776

29d. Date signed (Month, Day, Year)

4/19/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Doris Bustos 1160 Varnum St. NE #213 Wash., DC 20017

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Dr. Doris Bustos

State
Registrar

Baltimore, Maryland 21201-0020

Division of Vital Records, P.O. Box 68760,

Harold B. Jordan
04-2606
DOS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15444

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harold Bernard Jordan

2. Date of Death

April 15 2004

3. Time of Death

750 a M

4a. Facility Name (If not institution, give street and number)

931 Amer Drive

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince Georges

5. Social Security Number

577-60-9191

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

September 19, 1946

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

931 Amer Drive

10f. Zip Code

20744

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No June 1966
If Yes, Give Year or Dates: June 1969

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FIREMAN

16b. Kind of Business/Industry

District of Columbia Fire Department

17. Father's Name (First, Middle, Last)

Cushman Jordan

18. Mother's Name (First, Middle, Maiden Surname)

Helen Fletcher

19a. Informant's Name/Relationship (Type, Print)

Alfred Fletcher Jordan (Brother) 811 Drum Avenue; Capitol Heights, Maryland 20743

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

April 26, 2004 Cheltenham, Maryland Cheltenham Veterans Cemetery; Maryland

Date

Location - City or Town, State

21. Signature of Funeral Service Licensee

Kennamoh Cham

22. Name and Address of Facility

R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Contact gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

April 15, 2004

28b. Time of Injury

April 7 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

931 Amer Drive Fort Washington, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore H. King MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

April 16, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore H. King

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15445

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES

2. Date of Death

Month Day Year

APRIL 13 2004

3. Time of Death

04:06 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

237-70-9081

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 3, 1943

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

District of Columbia

10b. County

Washington

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3770 Hayes Street, N. E.; Apt. 1

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Receiving Manager

16b. Kind of Business/Industry

Marshall's Dept. Stores

17. Father's Name (First, Middle, Last)

Watson Jones

18. Mother's Name (First, Middle, Maiden Surname)

Evergreen Brown

19a. Informant's Name/Relationship (Type, Print)

Cruzalida Ramos Jones (Wife)
Darrell Jones (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8806 Woodstock Drive West; Upper Marlboro, Maryland 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

National Harmony Memorial Park Landover, Maryland

Date

April 20, 2004

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Kerrenah Chen

22. Name and Address of Facility

R. N. Horton Company Morticians, INC.
600 Kennedy Street, N.W.; Washington, D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LACTIC ACIDOSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
4 HOURS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RHEUMATIC HEART DISEASE
PULMONARY HYPERTENSION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

G. Bloomfield MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

APRIL 13 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GERALD BLOOMFIELD JOHN'S HOPKINS HOSPITAL BALTIMORE, MARYLAND 21205

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 902-687-6000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15446

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Arthur James Keener | | | | 2. Date of Death Month April Day 16 Year 2004 | | 3. Time of Death 11:59pm M | |
| 4a. Facility Name (If not institution, give street and number) Millenium Nursing & Rehab Center | | | | 4b. City, Town, or Location of Death Forestville | | 4c. County of Death Prince George | |
| 5. Social Security Number 578-18-1001 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 30, 1922 | |
| 9. Birthplace (State or Foreign Country) Wash, D.C. | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George | | 10c. City, Town or Location Forestville | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 7420 Marlboro Pike | | | | 10f. Zip Code 20747 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943 - 1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Delivery Man | | 16b. Kind of Business/Industry Private | |
| 17. Father's Name (First, Middle, Last) William Keener | | | | 18. Mother's Name (First, Middle, Maiden Surname) Virginia Brooks | | | |
| 19a. Informant's Name/Relationship (Type, Print) Barbara Myles/Niece | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1331 Savannah St. Se. #6, Wash, DC. 20032 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico National | | Date April 26, 2004 | | 20c. Location - City or Town, State Triangle, VA. | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA HYPERTENSION | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier  Attending Phy. | | 29c. License number D 52900 | | 29d. Date signed (Month, Day, Year) 4-23-04 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Musa Momoh, M.D. 8700 Central Ave. Ste 301, Landover, MD. 20785 | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature  | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15447

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MILDRED

KIRKSEY

2. Date of Death

Month Day Year
April 19 2004

3. Time of Death

3:35 P M

4a. Facility Name (If not institution, give street and number)

Larkin Chase Nursing Home

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

5. Social Security Number

578-44-5422

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 26 1927

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

11215 Maiden Drive

10f. Zip Code

20720

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 Yrs

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Fred Brown

18. Mother's Name (First, Middle, Maiden Surname)

Inez Wilson

19a. Informant's Name/Relationship (Type, Print)

Daphne VanBuren/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11215 Maiden Drive Bowie, Maryland 20720

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

4/24/2004

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

K. D. Marshall

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Coronary Heart Failure*

Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy
☐ Pregnant at time of death ☐ Other (specify)
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

General Debility

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D57028

29d. Date signed (Month, Day, Year)

4-21-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Itya Chopra M.D. 600 Ridgley Avenue # 231 Annapolis, Maryland 21401

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **AMEND ITEM #24a PER PHY 0831 5/13/04** **Certificate of Death**

Reg. No. **2004 15448**

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Geraldine Louise Keller | | 2. Date of Death Month April Day 16 Year 2004 | | 3. Time of Death 2:10 PM | |
| 4a. Facility Name (If not institution, give street and number) Washington County Hospital | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington County | |
| 5. Social Security Number 220-28-7889 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 71 Yrs. | |
| 8. Date of Birth (Month, Day, Year) Nov. 26, 1932 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 49 Fairground Ave. | | 10f. Zip Code 21740 | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dye Machine Operator | | 16b. Kind of Business/Industry Ribbon Mfg. Co. | |
| 17. Father's Name (First, Middle, Last) Russell Keller | | 18. Mother's Name (First, Middle, Maiden Surname) Hazel Thomas Keller Eaton | | | |
| 19a. Informant's Name/Relationship (Type, Print) Chris E. Keller/Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49 Fairground Ave. Hagerstown, Maryland 21740 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery | | 20c. Location - City or Town, State Apr. 19, 04 Hagerstown, Maryland | |
| 21. Signature of Funeral Service Licensee Daniel J. Pawley Jr. | | 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | |
| a. Atherosclerotic Cardiovascular disease | | | | | |
| Due to (or as a consequence of): | | | | | |
| b. Renal Failure | | | | | |
| Due to (or as a consequence of): | | | | | |
| c. | | | | | |
| Due to (or as a consequence of): | | | | | |
| d. | | | | | |
| 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown | | | | | |
| 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Daniel J. Pawley Jr. | | 29c. License number D28365 | | 29d. Date signed (Month, Day, Year) 4-18-04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANZAR, JSHAF 368 niles Street - Hagerstown MD 21740 | | | | | |
| 31. Date filed (Month, Day, Year) APR 19 2004 | | 32. Registrar's Signature Brian S. Sparks | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

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Division of Vital Records, P.O. Box 68760,

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1- For State Registrar **WiCHD, dq** State of Maryland / Department of Health and Mental Hygiene **Amend#20b, 04-29-04, PerFH** **Certificate of Death**

Reg. No.

2004 15449

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **William Knotts** 2. Date of Death Month **April** Day **20** Year **2004** 3. Time of Death **2220** M

Funeral
Director

4a. Facility Name (If not institution, give street and number) **PENINSULA REGIONAL MEDICAL CENTER** 4b. City, Town, or Location of Death **SALISBURY** 4c. County of Death **WICOMICO**

5. Social Security Number **213-24-2389** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **75** Yrs. 8. Date of Birth (Month, Day, Year) **July 25, 1928** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Wicomico** 10c. City, Town or Location **Fruitland** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **105 Station Street** 10f. Zip Code **21826** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☐ Married ☐ Widowed ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ☐ No If Yes, Give Year or Dates: **Korea** 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: **White**

14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **7** College (1-4or 5+) **---** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Truck Driver** 16b. Kind of Business/Industry **Preston Trucking**

17. Father's Name (First, Middle, Last) **Arlie --- Knotts** 18. Mother's Name (First, Middle, Maiden Surname) **Lida --- Pearson**

19a. Informant's Name/Relationship (Type, Print) **Debbie L. Trice (daughter)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **105 Station Street, Fruitland, Maryland 21826**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) **Maryland Veterans Cemetery** 20b. Place of Disposition (Name of cemetery, crematory or other place) **Hurlock, Maryland** 20c. Location - City or Town, State **Hurlock, Maryland**

21. Signature of Funeral Service Licensee **David H. Thompson CFSP** 22. Name and Address of Facility **Holloway Funeral Home Professional Association 501 Snow Hill Road, Salisbury, Maryland 21804**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Myocardial Infarction** 23b. Was decedent pregnant in the past 12 months? ☐ Yes ☐ No ☐ Unknown 23c. If yes, outcome of pregnancy ☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy ☐ Other (specify) ☐ Unknown 23d. Date of delivery Month Day Year

23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **Approximate Interval Between Onset and Death** **18 days**

18 days

12 yrs.

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☐ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **John R. McLean** 29c. License number **D25209** 29d. Date signed (Month, Day, Year) **April 26, 2004**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **John R. McLean MD 100 E. Carroll St. Salisbury Md 21801**

31. Date filed (Month, Day, Year) **APR 28 2004** 32. Registrar's Signature **Beverly B. Sparks**

State
Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15450

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH STATEN LITTLETON

2. Date of Death

Month Day Year

04

20

2004

3. Time of Death

8:35 A M

4a. Facility Name (If not institution, give street and number)

11358 SHARPTOWN ROAD

4b. City, Town, or Location of Death

MARDELA SPRINGS

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

218-30-2205

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

05-01-1934

9. Birthplace (State or Foreign Country)

WILLARDS, MD.

Usual Residence of Decedent

10a. State

MD

10b. County

WICOMICO

10c. City, Town or Location

MARDELA SPRINGS

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

11358 SHARPTOWN ROAD

10f. Zip Code

21837

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

HIGHWAY DEPARTMENT

17. Father's Name (First, Middle, Last)

RUFUS LITTLETON

18. Mother's Name (First, Middle, Maiden Surname)

MAUDE BAKER

19a. Informant's Name/Relationship (Type, Print)

SHIRLEY LITTLETON - SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11358 SHARPTOWN ROAD, MARDELA SPRINGS, MD. 21837

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CREMATORY OF DELMARVA

Date

04-22-2004

20c. Location - City or Town, State

DELMAR, DELAWARE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BOUNDS FUNERAL HOME, INC.

705 EAST MAIN STREET, SALISBURY, MARYLAND 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Ds.

Due to (or as a consequence of):

b. Metabolic Syndrome

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 yrs.

20 yrs.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death
☐ Pregnant at time of death ☐ Unknown☐ Ectopic pregnancy
☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Cardiac Arrhythmias

23e. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy performed?
☐ Yes ☒ No24b. Were autopsy findings available prior to completion of cause of death?
☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

024986

29d. Date signed (Month, Day, Year)

4/20/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert J. Reilly, MD, 510 Riverside Dr. Box 5, Salisbury, MD 21801

31. Date filed (Month, Day, Year)

APR 22 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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5/14

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15451

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Percy Wise Lawson | | | | 2. Date of Death Month Day Year April 15 2004 | | 3. Time of Death 5:00AM | |
| 4a. Facility Name (If not institution, give street and number) Mariner Health of Bethesda | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | |
| 5. Social Security Number 577-46-2868 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 68 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 13, 1935 | |
| 9. Birthplace (State or Foreign Country) Wash., DC | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State DC | | 10b. County | | 10c. City, Town or Location Washington | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1314 Massachusetts Ave., N.W. #201 | | | | 10f. Zip Code 20005 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Resident Manager | | 16b. Kind of Business/Industry Private | |
| 17. Father's Name (First, Middle, Last) Abraham Lawson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maria Brown | | | |
| 19a. Informant's Name/Relationship (Type, Print) Johnniteen Oates - Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #1 Morningside Ct., Silver Spring, MD 20904 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery | | Date 4/21/04 | | 20c. Location - City or Town, State Wash., DC | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| Approximate Interval Between Onset and Death | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier | | 29c. License number 00057124 | | 29d. Date signed (Month, Day, Year) 4/19/04 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Truong Bao, M.D. 13219 Executive Park Terrace, Germantown, MD | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15452

1- For
State
Registrar

| | | | | | | | | | |
|---|--|---|--|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Li Ying Fan Lee</u> | | | | 2. Date of Death Month <u>April</u> Day <u>25</u> Year <u>2004</u> | | 3. Time of Death <u>2:00 AM</u> | | |
| | 4a. Facility Name (If not institution, give street and number) <u>University of Maryland Medical System</u> | | | | 4b. City, Town, or Location of Death <u>Baltimore</u> | | 4c. County of Death <u>Baltimore City</u> | | |
| Funeral Director | 5. Social Security Number <u>604-07-6389</u> | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>73</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>May 10, 1930</u> | | |
| | 9. Birthplace (State or Foreign Country) <u>China</u> | | 10a. State <u>Cal.</u> | | 10b. County <u>Los Angeles</u> | | 10c. City, Town or Location <u>South Pasadena</u> | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number <u>1630- Bank Street</u> | | 10f. Zip Code <u>91030</u> | | 10g. Citizen of What Country? <u>Taiwan</u> | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>Chinese</u> | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>0</u> College (1-4 or 5+) <u></u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u> | | 16b. Kind of Business/Industry <u>At Home</u> | | 17. Father's Name (First, Middle, Last) <u>Zhi-Ting Lee</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>-- Wang</u> | |
| 19a. Informant's Name/Relationship (Type, Print) <u>Thomas Fan- Son</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>10709-Boswell La., Potomac, Md. 20854</u> | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Parklawn Cemetery</u> | | 20c. Location - City or Town, State <u>5/1/2004 Rockville, Md.</u> | |
| 21. Signature of Funeral Service Licensee <u>[Signature]</u> | | 22. Name and Address of Facility <u>Hysong Co., Inc.</u> <u>6510-16th St., NW, Wash., DC</u> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Pneumonia</u> Due to (or as a consequence of): <u>Renal cell carcinoma</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u></u> Due to (or as a consequence of): <u></u> | | Approximate Interval Between Onset and Death <u>10 days</u> <u>7 months</u> | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month <u></u> Day <u></u> Year <u></u> | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) <u></u> | |
| 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred <u></u> | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u></u> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <u></u> | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <u>[Signature]</u> | | 29c. License number <u>P17672</u> | | 29d. Date signed (Month, Day, Year) <u>April 25 2004</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>E Fontanilla 22 S Greene St Baltimore Maryland 21201</u> | |
| 31. Date filed (Month, Day, Year) <u>APR 29 2004</u> | | 32. Registrar's Signature <u>[Signature]</u> | | | | | | | |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15453

1- For State Registrar

Physician /Medical Examiner

| | | | | | | | | | |
|---|--|--|--|---|--------------------------------|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Maria G. Lemus | | | | 2. Date of Death Month APRIL Day 24 Year 2004 | | | | 3. Time of Death 4:12 P M | |
| 4a. Facility Name (If not institution, give street and number) BAYVIEW MEDICAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | | | 4c. County of Death | |
| 5. Social Security Number 212-61-9673 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 35 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 06-11-1968 | | 9. Birthplace (State or Foreign Country) El Salvador | |

Funeral Director

| | | | |
|--|----------------------------------|---|--|
| Usual Residence of Decedent | | | |
| 10a. State Maryland | 10b. County Montgomery | 10c. City, Town or Location Silver Spring | |
| 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |

| | | | | | |
|---|--|-------------------------------|--|---|--|
| 10e. Street and Number 12120 Selfridge Road | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? El Salvador | |
|---|--|-------------------------------|--|---|--|

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Salvadoran | | 14. Race - American Indian, Black, White, etc. Specify: White | |
|--|--|---|--|--|--|---|--|

| | | | | | |
|--|--|--|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dishwasher | | 16b. Kind of Business/Industry Manor Country Club | |
|--|--|--|--|---|--|

| | | | |
|--|--|--|--|
| 17. Father's Name (First, Middle, Last) Isac Lemus | | 18. Mother's Name (First, Middle, Maiden Surname) Romilia Rivera | |
|--|--|--|--|

| | | | |
|---|--|---|--|
| 19a. Informant's Name/Relationship (Type, Print) Francisco A. Lemus/Brother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12120 Selfridge Road Silver Spring, Maryland, 20906 | |
|---|--|---|--|

| | | | | | |
|---|--|--|--|---|--|
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cem. | | 20c. Location - City or Town, State 04-29-04 Silver Spring, Md. | |
|---|--|--|--|---|--|

| | | | |
|--|--|---|--|
| 21. Signature of Funeral Service Licensee Wanda C. Bacon, CC 361 | | 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Wash., D.C. 20010 | |
|--|--|---|--|

| | | | |
|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS WITH COMPLICATIONS | | Approximate Interval Between Onset and Death | |
|--|--|--|--|

| | | | |
|--|--|---|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Due to (or as a consequence of): DISSEMINATED STRONGYLOIDES INFECTION | |
| | | Due to (or as a consequence of): | |
| | | Due to (or as a consequence of): | |
| | | Due to (or as a consequence of): | |

| | | | | | |
|--|--|--|--|---|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
|--|--|--|--|---|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
|--|--|--|--|--|--|--|--|

| | | | |
|---|--|--|--|
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
|---|--|--|--|

| | | | |
|---|--|--|--|
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
|---|--|--|--|

| | | | | | | | | | |
|--|--|---------------------------------------|--|--|--|--|--|-----------------------------------|--|
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |

| | | | | | |
|---|--|---------------------------------------|--|--|--|
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29c. License number O C M E | | 29d. Date signed (Month, Day, Year) APRIL 25, 2004 | |
|---|--|---------------------------------------|--|--|--|

| | | | |
|---|--|---|--|
| 29b. Signature and title of certifier Mary C. Rippe | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | |
|---|--|---|--|

| | | | |
|---|--|---|--|
| 31. Date filed (Month, Day, Year) APR 29 2004 | | 32. Registrar's Signature [Signature] | |
|---|--|---|--|

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15454

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

| | | | | | |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Duke Lawrence Lee aka Logan Lee Maxwell | | | 2. Date of Death Month April Day 21 Year 2004 | | 3. Time of Death 7:50pm M |
| 4a. Facility Name (If not institution, give street and number) 7970 Lakecrest Drive | | | 4b. City, Town, or Location of Death Greenbelt | | 4c. County of Death Prince George's |
| 5. Social Security Number 408-73-7723 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 54 Yrs. | 8. Date of Birth (Month, Day, Year) Jan. 11, 1950 | | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Prince George's | 10c. City, Town or Location Greenbelt | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 7970 Lakecrest Drive | | | 10f. Zip Code 20770 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1960- If Yes, Give Year or Dates: 1964 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Car Sales | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retail | | 16b. Kind of Business/Industry Retail |
| 17. Father's Name (First, Middle, Last) Charles William Lee | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Irene Thomas | | |
| 19a. Informant's Name/Relationship (Type, Print) Ry P. Lee - Spouse | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7970 Lakecrest Drive, Greenbelt, Maryland 20770 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Location - City or Town, State 4/24/2004 Alexandria, Virginia | |
| 21. Signature of Funeral Service Licensee  | | | 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death |
| a. Acute Respiratory Failure Due to (or as a consequence of): | | | | | 1 Day |
| b. Congestive Heart Failure Due to (or as a consequence of): | | | | | 4 Years |
| c. Severe Coronary Artery Disease Due to (or as a consequence of): | | | | | 5 Years |
| d. | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Chronic Obstructive Pulmonary Disease Ascites | | | | | 23e. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number A21883 | | 29d. Date signed (Month, Day, Year) April 23, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hema P. Yadla, MD 9470 Annapolis Road, Suite 315, Lanham, Maryland 20706 | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature  | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15455

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLAUDIA M. S. LITTLE

2. Date of Death

Month Day Year
4 21 2004

3. Time of Death

3:35 P^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

GREATER LAUREL REGIONAL HOSPITAL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

577-58-5909

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
9 4 1944

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4503 Josephine Avenue

10f. Zip Code

20705

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Claudia Oscar Smith

18. Mother's Name (First, Middle, Maiden Surname)

Ivy Harris

19a. Informant's Name/Relationship (Type, Print)

Charles E. Little/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4503 Josephine Avenue Beltsville, Maryland 20705

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lincoln Cemetery

Date

4/26/04

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Septic Shock

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Anemia

Due to (or as a consequence of):

Sequentially list conditions,
starting with the immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of certifier

29c. License number

D0053210

29d. Date signed (Month, Day, Year)

4/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas N. Azing, M.D. 6201 Greenbelt Road Suite M-17 College Park, Md. 20740

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15456

Certificate of Death

Reg. No.

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Annie Caroline Elizabeth Robbins Lankford

2. Date of Death

April 16, 2004

3. Time of Death

7:50a^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Berlin Nursing & Rehabilitation Center

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

5. Social Security Number

265-03-9814

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 22, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10204 Germantown Road

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

laborer/cashier

16b. Kind of Business/Industry

Temple University

17. Father's Name (First, Middle, Last)

Riley

Robbins

18. Mother's Name (First, Middle, Maiden Surname)

Mary

Smack

19a. Informant's Name/Relationship (Type, Print)

Selena Purnell/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10204 Germantown Road - Berlin, Maryland 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

New Bethel Ch. Cem.

Date

04/24/2004

20c. Location - City or Town, State

Berlin, Maryland

21. Signature of Funeral Service Licensee

Patricia A. Jolley

22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD

JOLLEY MEMORIAL CHAPEL

21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Breast Cancer

Approximate
Interval Between
Onset and Death
YearsSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lasta. Due to (or as a consequence of):
Peripheral Vascular Disease

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

Dr. Braden

29c. License number

D28769

29d. Date signed (Month, Day, Year)

4/16/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas N. Borodulin, MD

1209 Coastal Highway
Fenwick Island, DE 19944

31. Date filed (Month, Day, Year)

APR 23 2004

32. Registrar's Signature

G Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Annie Caroline Elizabeth Robbins Lankford

LANKFORD, CARRIE
Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15457

1- For State Registrar AMEND ITEM #5 PER DWR G831 5/13/04 Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Maria Corina Melgar 2. Date of Death Month Day Year April 14, 2004 3. Time of Death 11:15PM

Funeral
Director

4a. Facility Name (If not institution, give street and number) 27 Heritage Court 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel

5. Social Security Number NONE 6. Sex 1 ☐ M 2 ☒ F 7. Age (In yrs. last birthday) 63 Yrs. 8. Date of Birth (Month, Day, Year) Oct. 3, 1940 9. Birthplace (State or Foreign Country) GuatemalaUsual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location Annapolis 10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 27 Heritage Court 10f. Zip Code 20401 10g. Citizen of What Country? Guatemala

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ Yes 2 ☐ No Specify: Guatemalan 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper 16b. Kind of Business/Industry Someone Else's Home

17. Father's Name (First, Middle, Last) Juan Antonio Melgar 18. Mother's Name (First, Middle, Maiden Surname) Juana Gonzalez

19a. Informant's Name/Relationship (Type, Print) Miriam Melgar/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50 Ave. C1-86 zona 11 Guatemala Guatemala

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Cuilapa Santa Rosa unk 20c. Location - City or Town, State Guatemala

21. Signature of Funeral Service Licensee Gladys A. Sewell 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC HEART DISEASE Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 3 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 23d. Date of delivery Month Day YearPart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Dr. A. AFRICANO MD 29c. License number D-19400 29d. Date signed (Month, Day, Year) 04-21-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTO AFRICANO, M.D. 344 UNIVERSITY BLVD W. SILVER SPRING

31. Date filed (Month, Day, Year) APR 23 2004 32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15458

1- For
State
Registrar

| | | | | | | | | |
|--|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harry Moore | | | | 2. Date of Death Month 04 Day 09 Year 2004 | | 3. Time of Death 2:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland Hospital | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 579-56-9429 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | 8. Date of Birth (Month, Day, Year) 4-25-45 | |
| | 9. Birthplace (State or Foreign Country) Washington DC | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10a. State MD | | 10b. County Prince Georges | | 10c. City, Town or Location Capital Heights | | | |
| | 10e. Street and Number 4729 Larry Gorham Dr | | | | 10f. Zip Code 20743 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decorator Interior/Exterior | | 16b. Kind of Business/Industry Home Improvements | |
| | 17. Father's Name (First, Middle, Last) Charles E. Moore Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lola Hymes | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Betty Moore/spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4729 Larry Gorham Dr. Capital Heights, MD 20743 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park | | 20c. Location - City or Town, State Landover, MD | |
| | 21. Signature of Funeral Service Licensee Chas H Henry | | | | 22. Name and Address of Facility B K Henry Funeral Chapel Inc. 420 H Street NE Washington DC 20002 | | | |
| | Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Sepsis due to Infection Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | Approximate Interval Between Onset and Death |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier [Signature] MD | | | | 29c. License number J13660 | | 29d. Date signed (Month, Day, Year) 04/09/04 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margarita Jovel, MD, University of Maryland Emergency Department Baltimore MD 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | | | 32. Registrar's Signature [Signature] | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For 4-30-04
State Registrar Amend #2. Per Phys. PGC cr

Certificate of Death

Reg. No. 2004 15459

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Laura Beatrice Mobley | | | | 2. Date of Death Month April Day 13 Year 2004 | | 3. Time of Death 7:42 A M | |
| | 4a. Facility Name (If not institution, give street and number) Prince George's Hospital | | | | 4b. City, Town, or Location of Death Cheverly | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 436-36-6702 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) July 9, 1921 | |
| | 9. Birthplace (State or Foreign Country) Mississippi | | 10a. State Maryland | | 10b. County Prince George | | 10c. City, Town or Location Largo | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 10907 Bennington Drive | | 10f. Zip Code 20774 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: African American | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician | | 16b. Kind of Business/Industry Self-Employed | | | |
| | 17. Father's Name (First, Middle, Last) Rance Dixon | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ella Evans | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Giffred Johnson - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10907 Bennington Dr., Largo, MD 20774 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematorium, etc.) Lakemont Memorial Gardens | | 20c. Location - City or Town, State Davidsonville, MD | | 20d. Date 4/24/2004 | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee John T. Stewart, III | | 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | | | | |
| To Be Completed by Physician/Medical Examiner | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 2-27-04 | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred FELL DOWN STAIRS AT HOME | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME 20774 | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10907 BENNINGTON DR LARGO, MD | | 28g. Date of Injury 20774 | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Dr. George Bone | | | | | |
| | 29c. License number D31069 | | 29d. Date signed (Month, Day, Year) APRIL 19, 2004 | | | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR GEORGE BONE 3001 HOSPITAL DRIVE CHEVERLY, MD 20785 | | 31. Date filed (Month, Day, Year) APR 26 2004 | | | | | |
| | 32. Registrar's Signature John T. Stewart, III | | 33. Date of Death APR 13 2004 | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Miguel Angel Martinez-Ramos
04-02977
RPD

pend item #23a, 27, PER ME, 6832, 6/17/04
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2004 15460

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Miguel Angel Martinez

2. Date of Death

Month Day Year
May 2, 2004

3. Time of Death

1244 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

none

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

21 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 28, 1983

9. Birthplace (State or Foreign Country)

Mexico

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Riverdale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5309 Riverdale Road #314

10f. Zip Code

20801

10g. Citizen of What Country?

Mexico

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Mexican

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Construction Worker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Margarito Martinez

18. Mother's Name (First, Middle, Maiden Sumame)

Paula Ramos

19a. Informant's Name/Relationship (Type, Print)

Eloy Martinez (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5610 54th Avenue, Riverdale, MD 20801

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cementary Pozo Bendito 5/8/2004 San Luis Potosi, Mexico

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon/Hale Funeral Home

9013 Annapolis Road, Lanham, MD 20706

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arrythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 2, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA RUBIO, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 04 2004

32. Registrar's Signature

[Signature]

3620

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For Amend Item #5 per fn 6831 5/18/04 as State of Maryland / Department of Health and Mental Hygiene 2004 15461
 Registrar 4-28-04 Amend #4b. Per Phys. PGC cr Certificate of Death Reg. No.

| | | | | | | | | |
|--|--|---|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Helen C. Mills | | | 2. Date of Death Month April Day 4th Year 2004 | | 3. Time of Death 12:48 P | | |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. 570-68-5757 578-68-5757 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) June 9, 1919 | |
| | 9. Birthplace (State or Foreign Country) South Carolina | | 10a. State DC | | 10b. County Washington | | 10c. City, Town or Location Washington | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 5812 Foote St., N.E. | | 10f. Zip Code 20019 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. African American | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Private | | | | |
| 17. Father's Name (First, Middle, Last) Silas P. Corley | | | 18. Mother's Name (First, Middle, Maiden Surname) Eva B. Harrison | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert T. Mills - Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Mace Dr., Ft. Wash., MD 20744 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery | | 20c. Date 4/10/2004 | | 20d. Location - City or Town, State Brentwood, MD | |
| 21. Signature of Funeral Service Licensee John T. Stewart III | | | 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Asystole Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. Methicillin-sensitive Staphylococcus aureus bacteremia Due to (or as a consequence of): d. End-stage renal disease | | | | | Approximate Interval Between Onset and Death week weeks years | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier Dr. Walcott M.D. | | 29c. License number DC054699 | | 29d. Date signed (Month, Day, Year) April 4, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen M. Walcott, M.D., 12201 Plum Orchard Dr., Silver Spring, MD 20904 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | | 32. Registrar's Signature [Signature] | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15462

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KIMBERLY ANN MICHELS

2. Date of Death

Month Day Year
APRIL 19 2004

3. Time of Death

7:40 A^M

4a. Facility Name (If not institution, give street and number)

National Institutes of Health

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

456-11-4575

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 17, 1955

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

LA

10b. County

St. Charles Parrish

10c. City, Town or Location

Destrehan

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

108 Laura Lane

10f. Zip Code

70047

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Veterinarian

16b. Kind of Business/Industry

Doctor of
Veterinary Medicine

17. Father's Name (First, Middle, Last)

Daniel Lawrence Michels

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Kricher

19a. Informant's Name/Relationship (Type, Print)

Chris LaGrange - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 Laura Lane Destrehan, LA. 70047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)
St. Charles Borromeo
Romeo Church Cem.

Date

4-22-2004

20c. Location - City or Town, State

Destrehan, LA.

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.
4217 9th St. NW Washington, D.C. 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. NEUTROPENIA FROM CHEMOTHERAPY

Due to (or as a consequence of):

c. METASTATIC BREAST CANCER

Due to (or as a consequence of):

d. PRIMARY BREAST CANCER

Approximate
Interval Between
Onset and Death

1 WEEK

NOV 2001

OCT 2000

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Michael R. Bishop

29c. License number

18909 (NE)

29d. Date signed (Month, Day, Year)

04/23/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL R. BISHOP

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15463

1- For
State
Registrar

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Adeline B. McKenney

2. Date of Death

April 21 2004

3. Time of Death

2:15 P^M

4a. Facility Name (If not institution, give street and number)

Clinton Nursing & Rehab. Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

578-03-2267

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 23, 1917

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9211 Stuart Lane

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, Asian, etc.

Specify: American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Federal Employee

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

John Bragg

18. Mother's Name (First, Middle, Maiden Surname)

Addie Branch

19a. Informant's Name/Relationship (Type, Print)

Joseph L. Bragg - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

95 W.95th St., Apt. 33E, New York, NY 10025

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial park 4/27/2004

Date

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End Stage Renal Disease

Due to (or as a consequence of):

Congestive Heart Failure

Due to (or as a consequence of):

Coronary Artery Disease

Due to (or as a consequence of):

Hypertension

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John T. Stewart III

29c. License number

D 51520

29d. Date signed (Month, Day, Year)

4-21-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bahram Pishdad, M.D. 1328 Southern Ave., S.E. #310, Wash., DC 20032

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Bahram Pishdad

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15464

1- For State Registrar

| | | | | | |
|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last) Eloise Berry Matthews | | 2. Date of Death Month Day Year April 25, 2004 | | 3. Time of Death 12:40 AM | |
| 4a. Facility Name (If not institution, give street and number) 14539 Jackson Boulevard | | 4b. City, Town, or Location of Death Eden | | 4c. County of Death Wicomico | |
| 5. Social Security Number 052-26-2522 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 70 Yrs. | |
| 8. Date of Birth (Month, Day, Year) August 30, 1933 | | 9. Birthplace (State or Foreign Country) New York | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Wicomico | | 10c. City, Town or Location Eden | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 14539 Jackson Boulevard | | 10f. Zip Code 21822 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) --- | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | 16b. Kind of Business/Industry Keen Welding | |
| 17. Father's Name (First, Middle, Last) George --- Berry | | | 18. Mother's Name (First, Middle, Maiden Surname) Hazel --- Unknown | | |
| 19a. Informant's Name/Relationship (Type, Print) Charles E. Matthews (husband) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14539 Jackson Boulevard, Eden, Maryland 21822 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens | | 20c. Location - City or Town, State April 28, 2004 Hebron, Maryland | |
| 21. Signature of Funeral Service Licensee  CFSP | | 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Road, Salisbury, Maryland 21804 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Approximate Interval Between Onset and Death 3 Years | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D0054879 | | 29d. Date signed (Month, Day, Year) 04/26/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Trueth 106 M. Howard Street Salisbury MD 21801 | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Register

MEND ITEM #291 PER PHY G831 5/13/04 Certificate of Death

Reg. No. 2004 15465

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Edward Francis McDonnell | | 2. Date of Death Month March Day 28, Year 2004 | | 3. Time of Death 11:05 P M | |
| 4a. Facility Name (If not institution, give street and number) Millenium Health & Rehab. Center | | 4b. City, Town, or Location of Death Ft. Washington | | 4c. County of Death Prince George's | |
| 5. Social Security Number 013-14-9246 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | |
| 8. Date of Birth (Month, Day, Year) 08/16/1919 | | 9. Birthplace (State or Foreign Country) Mass. | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Ft. Washington | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 1213 Firth of Lorne Circle | | 10f. Zip Code 20744 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) 11 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aircraft Mechanic | | 16b. Kind of Business/Industry Private Industry | |
| 17. Father's Name (First, Middle, Last) Daniel Joseph McDonnell | | 18. Mother's Name (First, Middle, Maiden Surname) Josephine Garvey | | | |
| 19a. Informant's Name/Relationship (Type, Print) JoAnn D. Dullahan / Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1213 Firth of Lorne Circle Ft. Wash., MD. 20744 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Kalas Crematory | | 20c. Location - City or Town, State 03/30/2004 Edgewater, Maryland | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. LUNG CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M 1 <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D48158 | | 29d. Date signed (Month, Day, Year) 03/20/2004 03/28/2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #500 Sisom Osia MD 6192 Oxon Hill Road Oxon Hill Maryland 20745 | | | | | |
| 31. Date filed (Month, Day, Year) MAR 30 2004 | | 32. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15466

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES J. NORMAN, II

2. Date of Death

Month Day Year
APRIL 21, 2004

3. Time of Death

11:00 PM

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

579-56-6406

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
MAY 22, 1945

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

SUITLAND

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5761 SUITLAND RD.

10f. Zip Code

20746

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

TIRE COMPANY

17. Father's Name (First, Middle, Last)

JAMES J. NORMAN, I

18. Mother's Name (First, Middle, Maiden Surname)

EDITH CURTIS

19a. Informant's Name/Relationship (Type, Print)

JAMES J. NORMAN, III (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

319 GROVE PARK RD., BROOKLYN, NY 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN CEMETERY

Date

4/28/04

20c. Location - City or Town, State

BRENTWOOD, MD

21. Signature of Funeral Service Licensee

Kenneth J. Robinson

22. Name and Address of Facility

PEYTON FUNERAL HOME

2205 S. SHIRLINGTON RD., ARLINGTON, VA 22206

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Cardiopulmonary Arrest*
Due to (or as a consequence of):*Half hour*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last.

b. *Congestive Cardiac Failure*
Due to (or as a consequence of):*Two weeks*c. *Chronic renal failure*
Due to (or as a consequence of):*Few years*

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M. Khan MD

29c. License number

D18895

29d. Date signed (Month, Day, Year)

April 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOBARAK KARIM, 7610 CARROLL AVE, STE 340, TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

APR 29 2004

32. Registrar's Signature

*John A. Smith*State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15467

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ryan McPherson O'Neal, Jr.

2. Date of Death

February 15 2004

3. Time of Death

0930A^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

056-68-9531

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Feb. 14, 2004

9. Birthplace (State or Foreign Country)

Silver Spring

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

210 Jill Lane T-1

10f. Zip Code

20724

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

n/a

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

n/a

infant

16b. Kind of Business/Industry

n/a

infant

17. Father's Name (First, Middle, Last)

Ryan M. O'Neal

18. Mother's Name (First, Middle, Maiden Surname)

Ebony A. Hinds-Evans

19a. Informant's Name/Relationship (Type, Print)

Ryan O'Neal/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

738 Lenox Road, Brooklyn, NY 11203

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Crem. at LP 3/1/04

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service licensee

22. Name and Address of Facility

Simple Tribute Funeral and Cremation Center
1040 Rockville Pike Rockville MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *cardiorespiratory failure*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *extreme prematurity.*

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 hrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Ectopic pregnancy
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Gregory J. Downing, MD PhD

29c. License number

H0045952

29d. Date signed (Month, Day, Year)

02-15-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORY J. Downing, 1520 Forest Glen Rd Silver Spring, MD

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15468

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD JEAN PETRY, SR.

2. Date of Death

Month 1, 2004 Year

3. Time of Death

1:37 PM

4a. Facility Name (If not institution, give street and number)

CARROLL HOSPITAL CENTER

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

5. Social Security Number

220-34-6652

6. Sex

M 2 F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month 9, 1937 Year

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

324 1/2 EAST MAIN STREET

10f. Zip Code

21157

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

LANDSCAPING

17. Father's Name (First, Middle, Last)

DONALD PETRY

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY CHALLIS

19a. Informant's Name/Relationship (Type, Print)

KATHERINE E. PETRY/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

324 1/2 EAST MAIN STREET, WESTMINSTER, MD 21157

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CARROLL CREMATION

Date

5/3/2004

20c. Location - City or Town, State

HAMPSTEAD, MARYLAND

21. Signature of Funeral Service Licensee

Swann & Gaherty Funeral Home, P.A.

22. Name and Address of Facility

91 WILLIS STREET, WESTMINSTER, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

Angina

b. Due to (or as a consequence of):

Hypertension

c. Due to (or as a consequence of):

Hyperlipidemia

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Right Subclavian Occlusion

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an
autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available
prior to completion of cause of
death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 Outpatient 3 DOA

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

29b. Signature and title of certifier

29c. License number

D0058246

29d. Date signed (Month, Day, Year)

5/3/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAJANI TADIMALLA, MD

912 Washington Rd
Westminster MD 21157

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

James A. Spotts

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15469

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Lillian B. Powell

2. Date of Death

Month

Day

Year

3. Time of Death

H

17

04

10:40P^M

4a. Facility Name (If not institution, give street and number)

Heartland Health Care Center

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

5. Social Security Number

577-84-3262

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

102

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

Sep. 27, 1901

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2207 Otis St., N.E.

10f. Zip Code

20018

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Robert Boston

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Wilson

19a. Informant's Name/Relationship (Type, Print)

Romaine Jenkins - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2207 Otis St., N.E. Wash., DC 20018

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

4/23/2004

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

John T. Stewart, III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atrial Fibrillation

Due to (or as a consequence of):

b. As thromb.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John T. Stewart, III

29c. License number

048077

29d. Date signed (Month, Day, Year)

4/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#210, Langley Park, MD. 20912. Dr. Alexander Yak

7676 New Hampshire Avenue

State Registrar

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

John T. Stewart, III

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15470

1- For State Registrar

| | | | | | | | | | | | | | |
|---|---|--|---|--|--|-------------------------------------|---|---|--|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LOUIS POSTON | | | | 2. Date of Death Month Day Year April 24, 2004 | | | | 3. Time of Death 1130 a^M | | | | |
| | 4a. Facility Name (If not institution, give street and number) Prince Georges Hospital Center | | | | 4b. City, Town, or Location of Death Cheverly | | | | 4c. County of Death Prince Georges | | | | |
| Funeral Director | 5. Social Security Number 219-11-0500 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 18 Yrs. | | 8. Date of Birth (Month, Day, Year) 11 3 1985 | | 9. Birthplace (State or Foreign Country) Maryland | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Prince George's | | 10c. City, Town or Location Landover | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number 1701 Belle Haven Drive | | | | 10f. Zip Code 20785 | | | | 10g. Citizen of What Country? U.S.A. | | | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student | | | | 16b. Kind of Business/Industry Private | | | | |
| | 17. Father's Name (First, Middle, Last) James Poston III | | | | 18. Mother's Name (First, Middle, Maiden Surname) Velina Harrison | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Velina R. Exum/Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 Belle Haven Drive Landover, Maryland 20785 | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Cemetery | | Date 5/3/2004 | | 20c. Location - City or Town, State Landover, Maryland | | | | |
| | 21. Signature of Funeral Service Licensee K. D. Marshall | | | | 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 Landover Road Landover, Maryland 20785 | | | | | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. gunshot wound of head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) 4-24-04 | | 28b. Time of Injury 02:10 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred subject shot | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Patricia Aronica-Pollak MD | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) April 25, 2004 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICIA ARONICA-POLLAK MD | | | | | | | | | | 31. Date filed (Month, Day, Year) APR 28 2004 | | | |
| 32. Registrar's Signature Heather K. Sparks | | | | | | | | | | 33. Date filed (Month, Day, Year) APR 28 2004 | | | |

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

CR 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15471

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nola MAe Perry

2. Date of Death

Month

Day

Year

3. Time of Death

04

13

2004

4:25 A M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

239-24-2863

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

04 28 20

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2601 Bel Pre Road

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

St. Elizabeths Hospital

17. Father's Name (First, Middle, Last)

Walter McCloud

18. Mother's Name (First, Middle, Maiden Surname)

Pearl A. Evans

19a. Informant's Name/Relationship (Type, Print)

Jacqueline Bibik, Attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3872 Wertz Drive, Woodbridge, Va. 22193

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rock Creek Cemetery

Date

4-24-04

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home

4217 9th. St. N.W. Washington, D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Sacral Decubitus Ulcer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Diabetes Mellitus

23a. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven Fong, M.D.

29c. License number

D0060552

29d. Date signed (Month, Day, Year)

4-13-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Fong, M.D. 19703 Executive Park Circle, Germantown, Md. 20874

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

Steven Fong

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15472

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

| | | | | | |
|--|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last) Virginia R. Pasca | | | 2. Date of Death Month April Day 22 Year 2004 | | 3. Time of Death 7:00 a^M |
| 4a. Facility Name (If not institution, give street and number) Milleneum Nursing Home | | | 4b. City, Town, or Location of Death Fort Washington | | 4c. County of Death Prince Georges |
| 5. Social Security Number 578-24-8880 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 Yrs. | 8. Date of Birth (Month, Day, Year) Feb. 11, 1921 | 9. Birthplace (State or Foreign Country) Illinois | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Prince Georges | 10c. City, Town or Location Fort Washington | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 10e. Street and Number 12021 Livingston Road | | | 10f. Zip Code 20744 | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) _____ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress | | 16b. Kind of Business/Industry Food Services | |
| 17. Father's Name (First, Middle, Last) Thomas J. Davis | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth R. Wooster | | |
| 19a. Informant's Name/Relationship (Type, Print) Richard J. Leonberger/Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 William Street Hammondsport NY 14840 | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Crematory 4/26/2004 Brentwood, Maryland | | 20c. Location - City or Town, State | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood Maryland 20722 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. Congestive Heart failure | | Approximate Interval Between Onset and Death 5years | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Anemia | | 3years | |
| | | c. Upper Gastro Intestinal Bleeding | | 3years | |
| | | d. Coronary Artery Disease | | 10years | |
| | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 4 <input type="checkbox"/> Pregnant at time of death 9 <input type="checkbox"/> Unknown | | 23d. Date of delivery Month _____ Day _____ Year _____ | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D-24535 | | 29d. Date signed (Month, Day, Year) April 26, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Laxima Berwa 7700 Old Branch Ave. #C101 Clinton, MD 20735 | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15473

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCIS LLOYD PERRY Jr.

2. Date of Death

Month Day Year
April 20 2004

3. Time of Death

23:30 P^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGE'S HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

578-58-3853

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10 5 1943

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5403 Ellerbie Street

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Francis Lloyd Perry Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Butler

19a. Informant's Name/Relationship (Type, Print)

Ernestine Perry/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5403 Ellerbie Street Lanham, Maryland 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lincoln Cemetery

Date

4/26/2004

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J. B. Jenkins Funeral Home
7474 Landover Road Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Carcinoma of Lung

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rodger Ingham M. C. 6510 Kenilworth Avenue # 2400 Riverdale, Maryland 20735

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15474

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret C. Quartucci

2. Date of Death

Month 7 Day 2004

3. Time of Death

9:00 P^MFuneral
Director

4a. Facility Name (If not institution, give street and number)

13705 Cecil Ave

4b. City, Town, or Location of Death

Cresaptown

4c. County of Death

Allegany

5. Social Security Number

213-22-3523

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) July 14, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State Maryland

10b. County Allegany

10c. City, Town or Location Cresaptown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

13705 Cecil Ave

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Pietro Prato

18. Mother's Name (First, Middle, Maiden Surname)

Michelina Sicoli

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Rotruck-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13800 Blue Jay Dr., Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rest Lawn Mausoleum

Date

May 10, 2004

20c. Location - City or Town, State

LaVale, MD 21502

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hafer Funeral Service, PA

1302 National Hwy, LaVale, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Breast CA

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anita M Vagaroas

1313 National Hwy LaVale, MD 21502

31. Date filed (Month, Day, Year)

MAY 13 2004

32. Registrar's Signature

Anita M Vagaroas

ORIGINAL

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #31. Per VR PGC cr

Certificate of Death

Reg. No. 2004 15475

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLARICE, RICHARDSON

2. Date of Death

Month Day Year
04 21 2004

3. Time of Death

02:25M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

5. Social Security Number

579-72-6854

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 23, 1952

9. Birthplace (State or Foreign Country)

Wash.D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Brentwood

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4525 41st Ave.

10f. Zip Code

20722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Child Care Provider

16b. Kind of Business/Industry

Daycare (self)

17. Father's Name (First, Middle, Last)

William Draughn

18. Mother's Name (First, Middle, Maiden Sumame)

Mattie Belle Saunders

19a. Informant's Name/Relationship (Type, Print)

Daniel Richardson Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13901 Castle Blvd.#23 Silver Spring,Md.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverdale Pk.Crem

Date

May 3,04

20c. Location - City or Town, State

Riverdale,MD.

21. Signature of Funeral Service Licensee

Francis B. Hunt

22. Name and Address of Facility

Hunt Funeral Home

908 Kennedy St.N.W.Wash.D.C.20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure

Due to (or as a consequence of):

b. Dilated Cardiomyopathy

Due to (or as a consequence of):

c. Coronary artery disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Asthma exacerbation
- Ventricular arrhythmia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

X ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Khalid H. Ashai M.D.

29c. License number

060339

29d. Date signed (Month, Day, Year)

4/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid H. Ashai M.D. 3001 Hospital Dr.Cheverly,MD.@)*%

31. Date filed (Month, Day, Year)

4/22/04 APR 30 2004

32. Registrar's Signature

Khalid H. Ashai

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15476

1- For State Registrar

| | | | | | | | | |
|---|--|---|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) R.C. Russell Robinson | | | | 2. Date of Death Month Day Year April 25, 2004 | | 3. Time of Death 3:25 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Prince Georges Hospital | | | | 4b. City, Town, or Location of Death Cheverly | | 4c. County of Death Prince Georges | |
| Funeral Director | 5. Social Security Number 246-18-0151 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 24, 1925 | |
| | 9. Birthplace (State or Foreign Country) North Carolina | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State MD. | | 10b. County Prince Georges | | 10c. City, Town or Location Seat Pleasant | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 304 69th Place | | | | 10f. Zip Code 20743 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Forman | | | 16b. Kind of Business/Industry Construction | | |
| | 17. Father's Name (First, Middle, Last) Claude Robinson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Annie Redding | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Saundria Parker(Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5840 Cameron Run Terr. #433, Alexandria, Virginia 22303 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park 5-1-04 | | Date Landover, Md. | | 20c. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Lewis Funeral Home 311 N. Patrick St., Alexandria, Va. | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. Due to (or as a consequence of): Septic Shock</p> <p>b. Due to (or as a consequence of): Infected decubiti</p> <p>c. Due to (or as a consequence of): Urinary tract infection</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> | | | | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | | | 23d. Date of delivery Month Day Year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D20251 | | 29d. Date signed (Month, Day, Year) 4/27/2004 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr GITA K. SHAH 7350 Van Dusen Rd #220 Laurel MD 20707 | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 29 2004 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15477

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Michael Alan Rietzler

2. Date of Death

April 28, 2004

3. Time of Death

4:09 p M

4a. Facility Name (If not institution, give street and number)

8123 Gavin Street

4b. City, Town, or Location of Death

New Carrollton

4c. County of Death

Prince George's

5. Social Security Number

212-80-9009

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

36 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 11, 1968

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

New Carrollton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8123 Gavin Street

10f. Zip Code

20784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Pipe Installer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Joachim Martin Rietzler

18. Mother's Name (First, Middle, Maiden Surname)

Carolyn Anne Reed

19a. Informant's Name/Relationship (Type, Print)

Martin Rietzler - Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8123 Gavin Street, New Carrollton, MD 20784

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

4/30/2004

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Provider

22. Name and Address of Facility

Gasch's Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Gunshot wound to head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)
April 28, 2004

28b. Time of Injury

1600 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Shot himself in head

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

8123 Gavin St.
New Carrollton, MD 2078429a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

April 30, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador S. Votaw, MD Hospital Drury Chavely, Maryland

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15478

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Rosario M. Rusher

2. Date of Death

Month Day Year
APRIL 23 2004

3. Time of Death

6:37 AM

Funeral Director

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

126-24-5754

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10-07-1930

9. Birthplace (State or Foreign Country)

Puerto Rico

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6314 93rd Ave.

10f. Zip Code

20706

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Thomas Rivera

18. Mother's Name (First, Middle, Maiden Surname)

Guerllmina Geigel

19a. Informant's Name/Relationship (Type, Print)

James W. Rusher/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6314 93rd Ave., Lanham, MD 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cem. 04/30/04 Cheltenham, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J.B. Jenkins Funeral Home
7474 Landover Rd., Landover, Md. 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PULMONARY EMBOLISM

Approximate Interval Between Onset and Death

20 MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter in descending order (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

PERIPHERAL NEUROPATHY

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. Dashottar

29c. License number

D 25977

29d. Date signed (Month, Day, Year)

4.27.04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. DASHOTTAR, MD, 7207 HANOVER PARK MD #A, GREENBELT MD 20770

31. Date filed (Month, Day, Year)

APR 28 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15479

1- For State Registrar

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>ETHEL ROBINSON</i> | | | | 2. Date of Death Month Day Year April 18, 2004 | | 3. Time of Death AM PM 9:45 M | | |
| | 4a. Facility Name (If not institution, give street and number) Heartland Healthcare Hyattsville | | | 4b. City, Town, or Location of Death Hyattsville | | 4c. County of Death Prince Georges | | | |
| Funeral Director | 5. Social Security Number 577-72-3383 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 96 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 16, 1907 | | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State D.C. | | 10b. County Washington | | 10c. City, Town or Location Washington | | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 4908 Kansas Ave., N.W. | | 10f. Zip Code 20011 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic Worker | | 16b. Kind of Business/Industry Private | | | | | |
| 17. Father's Name (First, Middle, Last) George Colbert | | | | 18. Mother's Name (First, Middle, Maiden Sumame) Martha unk. | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Gladys Gartrell/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4908 Kansas Ave., N.W. Wash. D.C. 20011 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem Pk. | | 20c. Location - City or Town, State Landover, MD. | | 20d. Date 4/24/04 | | | |
| 21. Signature of Funeral Service Licensee <i>Beha Jenkins</i> | | | | 22. Name and Address of Facility Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash. D.C. 20011 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>ATHEROSCLEROTIC HEART DISEASE</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown | | | | 23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) N/A 9 <input type="checkbox"/> Unknown | | | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ALZHEIMERS DEMENTIA DEBRITUS ULCERS, URINARY TRACT INFECTION FAILURE TO THRIVE</i> | | | | | | | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Doris V. Pablo-Bustos</i> | | | | 29c. License number D 0058776 | | 29d. Date signed (Month, Day, Year) 4/20/04 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doris V. Pablo-Bustos 1160 Varnum Street, NE Wash. DC Suite 213 20017 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | | | 32. Registrar's Signature <i>Beha Jenkins</i> | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15480

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) JOHN STAMBAUGH | | 2. Date of Death Month MAY Day 5 Year 2004 | | 3. Time of Death 4:05 P M | |
| 4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL | | 4b. City, Town, or Location of Death FREDERICK | | 4c. County of Death FREDERICK | |
| 5. Social Security Number 216-14-6506 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 93 Yrs. | |
| 8. Date of Birth (Month, Day, Year) May 5, 1911 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| 10a. State Maryland | | 10b. County Carroll County | | 10c. City, Town or Location Keymar | |
| 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 7311 Keysville Road | | 10f. Zip Code 21757 | |
| 10g. Citizen of What Country? United States | | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) grocer | | 16b. Kind of Business/Industry grocery store | |
| 17. Father's Name (First, Middle, Last) J. Curtis Stambaugh | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Forney | | | |
| 19a. Informant's Name/Relationship (Type, Print) Larry W. Stambaugh / son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7135 Keysville Road Keymar, Maryland 21757 | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Keysville Union Cem. | | 20c. Location - City or Town, State Keymar, Maryland | |
| 21. Signature of Funeral Service Licensee <i>Alan C. Davis</i> | | 22. Name and Address of Facility Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure | | a. Due to (or as a consequence of): Acute Myocardial Infarction | | Approximate Interval Between Onset and Death days | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Due to (or as a consequence of): Atherosclerotic Cardiovascular Dis | | days | |
| | | c. Due to (or as a consequence of): | | year | |
| | | d. | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown | | 3 Ectopic pregnancy 5 Other (specify) | |
| 23d. Date of delivery Month Day Year | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD | | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | | |
| 24a. Was an autopsy performed? 1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | |
| 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Allen J. Gilson MD</i> | | 29c. License number D26516 | | 29d. Date signed (Month, Day, Year) MAY 6 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALLEN J. GILSON MD 1475 TANEY AVE FRED MD 21702 | | | | | |
| 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature <i>Alan C. Davis</i> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15481

Baltimore, Maryland 21215-0036

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) Jean Prescott Schiffman | | 2. Date of Death Month Day Year April 29, 2004 | | 3. Time of Death 2:25 p.m. | |
| 4a. Facility Name (If not institution, give street and number) Crofton Convalescent Center | | | 4b. City, Town, or Location of Death Crofton | | 4c. County of Death Anne Arundel |
| 5. Social Security Number 215-16-0477A | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | 8. Date of Birth (Month, Day, Year) Jan. 31, 1912 | 9. Birthplace (State or Foreign Country) Washington, D.C. |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Prince George's | 10c. City, Town or Location College Park | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 4912 Muskogee Street | | 10f. Zip Code 20740 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | |
| 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone Operator | | 16b. Kind of Business/Industry Telephone Company | | | |
| 17. Father's Name (First, Middle, Last) James P. McKallor | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma E. Alsop | | |
| 19a. Informant's Name/Relationship (Type, Print) Peggy A. Foster - Daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11609 34th Place, Beltsville, MD 20705 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Location - City or Town, State Alexandria, Virginia | |
| 21. Signature of Funeral Service Licensee Claudette Dash Lanning | | 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | Approximate Interval Between Onset and Death 1 year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. Signature and title of certifier D. Schiffman MD | | 29c. License number D38958 | | 29d. Date signed (Month, Day, Year) 4/29/04 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Daleit Singh Gethu 1413 Annapolis Road #106 Odenton MD 21113 | | | | | |
| 31. Date filed (Month, Day, Year) | | 32. Registrar's Signature | | | |

State Registrar

Lynda Crosson Seals
04-2747
MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15482

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lynda C. Seals

2. Date of Death

April 21, 2004

3. Time of Death

1530 P M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

218-74-4724

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

October 27, 1954

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3616 Village Drive North

10f. Zip Code

20772

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Medical Discharger

16b. Kind of Business/Industry

U.S. Army (Retired)

17. Father's Name (First, Middle, Last)

Thomas Crosson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Minnie J. Johnson

19a. Informant's Name/Relationship (Type, Print)

Minnie J. Johnson (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3298 Fort Lincoln Drive N.E. Apt. #409 Washington, D.C. 20018

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

April 30, 2004

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

ROLLINS FUNERAL HOME, INC.

4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Head and neck injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

4-21-04

28b. Time of Injury

1:39 P M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Driver of a motor vehicle which struck a fixed object.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Road

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/B Rt 4 South of Woodyard Upper Marlboro MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] LING LI, M.D.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

April 22, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LING LI, M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 29 2004

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15483

1- For State Registrar

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) Hazel C. Smith
2. Date of Death Month April Day 22 Year 2004
3. Time of Death 6:50 P M

Funeral Director

4a. Facility Name (If not institution, give street and number) Millennium at South River
4b. City, Town, or Location of Death Edgewater
4c. County of Death Anne Arundel

5. Social Security Number 212-24-4641
6. Sex 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday) 77 Yrs.
8. Date of Birth (Month, Day, Year) Oct. 24, 1926
9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent

10a. State Maryland
10b. County Prince George's
10c. City, Town or Location Lanham
10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 4920 Whitfield Chapel Road
10f. Zip Code 20706
10g. Citizen of What Country? United States

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife
16b. Kind of Business/Industry Private

17. Father's Name (First, Middle, Last) Ignatius Jones
18. Mother's Name (First, Middle, Maiden Surname) Lillian Maynard

19a. Informant's Name/Relationship (Type, Print) Richard S. Smith, Sr. - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6207 Willow Way, Clinton, MD 20735

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery
20c. Location - City or Town, State Clinton, MD
Date 4/28/2004

21. Signature of Funeral Service Licensee John T. Stewart II
22. Name and Address of Facility Stewart Funeral Home
4001 Benning Rd., N.E. Wash., DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on one line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia
Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascular Accident
General Debility
23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number D57028
29d. Date signed (Month, Day, Year) 4-27-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADITYA CHOPRA, MD 600 Ridgely Ave. Ste. 231 Annapolis, MD 21401

31. Date filed (Month, Day, Year) APR 29 2004
32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State 4-29-04
Registrar Amend #26. Per Phys. PGC cr

Certificate of Death

Reg. No.

2004 15484

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Juanita Genevieve Southern | | 2. Date of Death Month Day Year April 15 2004 | | 3. Time of Death 5:38 P M | |
| 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | 4b. City, Town, or Location of Death Takoma Park | | 4c. County of Death Montgomery | |
| 5. Social Security Number 578-26-3238 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 95 Yrs. | 8. Date of Birth (Month, Day, Year) Dec. 3, 1908 | | 9. Birthplace (State or Foreign Country) Wash., DC |
| Usual Residence of Decedent | | | | | |
| 10a. State DC | 10b. County | 10c. City, Town or Location Washington | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1200 Delaware Ave., S.W. #824 | | 10f. Zip Code 20024 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Associate | |
| 16b. Kind of Business/Industry Private | | 17. Father's Name (First, Middle, Last) Robert H. Sims | | 18. Mother's Name (First, Middle, Maiden Surname) Maria Garrison | |
| 19a. Informant's Name/Relationship (Type, Print) Myra B. Kennedy - Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2210 Apache St., Adelphi, MD 20783 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National | | 20c. Location - City or Town, State 5/3/2004 Arlington, VA | |
| 21. Signature of Funeral Service Licensee John T. Stewart III | | 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Cerebrovascular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cerebrovascular accident Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input checked="" type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Elwin Bustos | | 29c. License number 42936 | | 29d. Date signed (Month, Day, Year) April 16, 2004 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elwin Bustos, M.D. 1160 Varnum St., N.E. Wash., DC 20017 | | | | | |
| 31. Date filed (Month, Day, Year) APR 29 2004 | | 32. Registrar's Signature John T. Stewart III | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15485

1- For State Registrar Amend #'s 12.13. Per FH PGC 4-27-04 Certificate of Death

Reg. No.

Physician
/Medical
Examiner1. Decedent's Name (First, Middle, Last)
Mary E. Stewart2. Date of Death
April 24, 20043. Time of Death
7:15am4a. Facility Name (If not institution, give street and number)
Washington Adventist Hospital4b. City, Town, or Location of Death
Tokoma Park4c. County of Death
MontgomeryFuneral
Director5. Social Security Number
578-64-75406. Sex
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)
88 Yrs.If Under 1 Year
Months Days Hours Min.8. Date of Birth
Nov. 28, 19159. Birthplace (State or Foreign Country)
La Plata, Md.

Usual Residence of Decedent

10a. State
Md.10b. County
P.G.10c. City, Town or Location
Adelphi10d. Inside City Limits
1 ☒ Yes 2 ☐ No10e. Street and Number
8308 Curry Place10f. Zip Code
2078310g. Citizen of What Country?
U.S. A.11. Marital Status
1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates: ~~no~~13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify: ~~no~~14. Race - American Indian,
Black, White, etc.
Specify: Black15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4or 5+)16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Cashier/ Sales16b. Kind of Business/Industry
Retail17. Father's Name (First, Middle, Last)
Benjamin Milburn18. Mother's Name (First, Middle, Maiden Surname)
Idell Thomas19a. Informant's Name/Relationship (Type, Print)
Brenda E. Trueheart19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8308 Curry Place Adelphi, Md. 2078320a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)
Lincoln MemorialDate
April 30
200420c. Location - City or Town, State
Suitland, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Robinson Funeral Home 1313 6th st. N.W.
Wash., D.C. 2000123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Acute myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify)23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage renal disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)27. Manner of Death
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of Injury
M28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier (Check only one)
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
APR 27 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2004 15486

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CECELIA

SCOTT

2. Date of Death

April 23, 2004 Year

3. Time of Death

5:10am M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

579-07-4881

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 15, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

700 7th St., S.W. #321

10f. Zip Code

20024

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Preston Penny

18. Mother's Name (First, Middle, Maiden Surname)

Donza Penny

19a. Informant's Name/Relationship (Type, Print)

Evelyn S. Boyd/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11911 St Francis Way, Mithcellville Md. 20721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Mem. Cem.

Date

4/30/04

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Johnson & Jenkins Inc.

716 Kennedy St., N.W. Wash. D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

Approximate Interval Between Onset and Death
DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

COLITIS

DAYS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEHYDRATION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

XX Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

XX

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D32332

29d. Date signed (Month, Day, Year)

4/25/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh K Gupta. M.D. 9801 Georgia Ave #220 Silver SPRING Md. 20902

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15487

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Maria Stewart

2. Date of Death

Month 04 Day 11 Year 2004

3. Time of Death

7:15 A M

4a. Facility Name (If not institution, give street and number)

Mariner Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

MONTgomery

5. Social Security Number

251-10-0057

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

101

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Sept 22, 1902

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

901 Arcola Ave

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 yrs.

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

S.C. Public Schools

17. Father's Name (First, Middle, Last)

Frank Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Metts

19a. Informant's Name/Relationship (Type, Print)

Willie Akorli - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4141 Southern Ave. #101
Capitol Heights, Md. 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rolling Green Mem Pk 4-20-2004 Westchester, PA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.
4217 9th St. N.W. Washington, DC 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

2 Months

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. P. Marshall

29c. License number

D42578

29d. Date signed (Month, Day, Year)

4/15/2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gul Chabani 1500 Forest Glenn Rd. Silver Spring, Md.

31. Date filed (Month, Day, Year)

APR 27 2004

32. Registrar's Signature

J. P. Marshall

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15488

1- For
State
Registrar

| | | | | | |
|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ELNORA SAWYER | | 2. Date of Death Month Day Year APRIL 22, 2004 | | 3. Time of Death 1:30P M |
| | 4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL | | 4b. City, Town, or Location of Death CLINTON | | 4c. County of Death PRINCE GEORGES |
| Funeral Director | 5. Social Security Number 256 58 3810 | 6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 65 Yrs. | 8. Date of Birth (Month, Day, Year) APRIL 26, 1938 | 9. Birthplace (State or Foreign Country) FLORIDA |
| | Usual Residence of Decedent | | | | |
| 10a. State MARYLAND | | 10b. County PRINCE GEORGES | 10c. City, Town or Location CLINTON | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 9106 PINEVIEW LANE | | 10f. Zip Code 20735 | | 10g. Citizen of What Country? UNITED STATES | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | |
| 16b. Kind of Business/Industry DOMESTIC | | 17. Father's Name (First, Middle, Last) MONROE BUTLER | | 18. Mother's Name (First, Middle, Maiden Surname) NELLIE ADDISON | |
| 19a. Informant's Name/Relationship (Type, Print) CAROLYN STANFIELD / DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7811 JAYWICK AVE. FORT WASHINGTON, MD 20744 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) COCONUT GROVE CEM. | | 20c. Location - City or Town, State 01-MAY-2004 COCONUT GROVE, FL | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest Septic Shock Large Bowel Obstruction | | 23b. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown | | 23c. Date of delivery Month Day Year | |
| 23d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, seizure disorder, Dementia | | 23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | |
| 29c. License number D46374 | | 29d. Date signed (Month, Day, Year) 4/23/04 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Ave SE Washington DC 20032 | |
| 31. Date filed (Month, Day, Year) APR 27 2004 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15489

1- For State Registrar

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Joseph Salb, Jr.

2. Date of Death

April 21, 2004

3. Time of Death

0930 M

Funeral
Director

4a. Facility Name (If not institution, give street and number)

105 Roosevelt Avenue

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

213-44-3666

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 12, 1944

9. Birthplace (State or Foreign Country)

Wash. D.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

105 Roosevelt Avenue

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steamfitter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Charles Joseph Salb, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Margaret P. McLane

19a. Informant's Name/Relationship (Type, Print)

Margaret P. Salb - mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8140 Blue Finch Way, New Port Richey, FL. 34653

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date 04-22-04

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

E. Brian Powell

22. Name and Address of Facility

Beall Funeral Home
6512 N.W. Crain Hwy., Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Hyperlipidemia

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William P. Jones, MD Deputy

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

4/22/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD 695 America 21035

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

John E. Jones

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #23a PER PHY G831 5/13/04 JH Certificate of Death

Reg. No. 2004 15490

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)
Alta Venita Sprecher

2. Date of Death
Month Day Year
March 14, 2004

3. Time of Death
12:20am

4a. Facility Name (If not institution, give street and number)
Williamsport Nursing Home

4b. City, Town, or Location of Death
Williamsport

4c. County of Death
Washington

Funeral
Director

5. Social Security Number
215-14-2516

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
87 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)
Feb. 15, 1917

9. Birthplace (State or Foreign Country)
MD

Usual Residence of Decedent

10a. State
MD

10b. County
Washington

10c. City, Town or Location
Hagerstown,

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number
16042 National Pike

10f. Zip Code
21740

10g. Citizen of What Country?
U.S.A.

11. Marital Status
1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
8th grade 0

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Seamstress

16b. Kind of Business/Industry
garment mfg.

17. Father's Name (First, Middle, Last)
George Thomas Hose

18. Mother's Name (First, Middle, Maiden Surname)
Gwendola Boppe

19a. Informant's Name/Relationship (Type, Print)
Jeanette Robison daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11452 Englewood Rd. Hagerstown, MD 21740

20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Memorial Park

20c. Location - City or Town, State
Hagerstown, MD

21. Signature of Funeral Service Licensee
Donald Edwin Thompson Funeral Home, Inc
P.O. BOX 310 Clear Spring, MD 21722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ~~Acute Aspiration~~ ACUTE ASPIRATION 10 minutes

Due to (or as a consequence of):
b. Projectile Vomiting 10 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Small Bowel Obstruction 36 hours

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Senile dementia

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death
1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury
M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
TED E. HOWE 7542 Overlook Dr. Boonsboro, MD

31. Date filed (Month, Day, Year)
MAR 16 2004

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
Wash. # 23A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15491

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harold E. Snoots

2. Date of Death
Month Day Year
April 27, 20043. Time of Death
7:45 A MFuneral
Director

4a. Facility Name (If not institution, give street and number)

607 Mary Street

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

218-30-2807

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 29, 1932

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State
Maryland10b. County
Frederick10c. City, Town or Location
Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

607 Mary Street

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1954-195513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Produce Manager

16b. Kind of Business/Industry

Retail Grocery

17. Father's Name (First, Middle, Last)

Ralph Snoots

18. Mother's Name (First, Middle, Maiden Surname)

Mary Wenner

19a. Informant's Name/Relationship (Type, Print)

Kathy Doody/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

118 Darby Road New Market, Maryland 21774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Memorial Park

Date

April 30, 2004

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

M01386

22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Liver Failure

Due to (or as a consequence of):

b. Colon Cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death
1 month

5 years

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify)
9 ☐ Unknown23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 41866

29d. Date signed (Month, Day, Year)

April 27, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kanan Hudhudi, 46 B Thomas Johnson Drive Frederick MD 21702

State
Registrar

31. Date filed (Month, Day, Year)

APR 30 2004

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15492

1- For
State
RegistrarPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Beverley Victoria Selzer

2. Date of Death

Month Day Year

April 20 2004 18:30 P^M

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

261-62-9505

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 6, 1940

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

227 Canal Park Drive Unit #405

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retail Sales

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Karol J. Gebo, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Margaret --- Bondurant

19a. Informant's Name/Relationship (Type, Print)

William Selzer (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

227 Canal Park Drive, #405, Salisbury, Maryland 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parsons Cemetery

Date

April 24, 2004

20c. Location - City or Town, State

Salisbury, Maryland

21. Signature of Funeral Service Licensee

Keith R. Dumas CFSP

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Road, Salisbury, Maryland 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Pancreatic Carcinoma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Alon Davis MD

29c. License number

054127

29d. Date signed (Month, Day, Year)

4/20/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alon Davis MD 100 Power Street Salisbury MD 21804

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Beverly Selzer

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Beverly Selzer 261-62-9505

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15493

1- For State Registrar

| | | | | | | | |
|---|---|--|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Linda Susan Sharp | | | 2. Date of Death Month April Day 19 Year 2004 | | 3. Time of Death 12:12 PM | |
| | 4a. Facility Name (If not institution, give street and number) 4505 Public Landing Wharf Road | | | 4b. City, Town, or Location of Death Snow Hill | | 4c. County of Death Worcester | |
| Funeral Director | 5. Social Security Number 175-60-9668 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 40 Yrs. | 8. Date of Birth (Month, Day, Year) January 16, 1964 | | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Worcester | | 10c. City, Town or Location Snow Hill | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 4505 Public Landing Wharf Road | | | 10f. Zip Code 21863 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Assistant | | 16b. Kind of Business/Industry Hospitality | | |
| | 17. Father's Name (First, Middle, Last) James Russell Carr | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen --- Mayes | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Denny M. Sharp (husband) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4505 Public Landing Wharf Road, Snow Hill, Maryland 21863 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Spence Baptist Church Cemetery | | 20c. Location - City or Town, State April 22, 2004 Snow Hill, Maryland | | |
| | 21. Signature of Funeral Service Licensee Walter R. Denny CFS | | | 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Road, Salisbury, Maryland 21804 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. STARVATION Due to (or as a consequence of): b. BLUEL OBSTRUCTION Due to (or as a consequence of): c. OVARIAN CARCINOMA Due to (or as a consequence of): d. | | | | | | |
| | 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown 23d. Date of delivery Month Day Year | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier William P. McGuire 29c. License number D16801 29d. Date signed (Month, Day, Year) 4-21-04 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DR. BALTIMORE, MD 21237 | | | | | | | |
| 31. Date filed (Month, Day, Year) APR 22 2004 32. Registrar's Signature B Sparks | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend Item #10b per in 6331 5/18/04 tas
 State of Maryland Department of Health and Mental Hygiene
 Certificate of Death
 Reg. No. 2004 15494

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10+1VA
 30

Physician
 /Medical
 Examiner

Funeral
 Director

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Harry James Smith | | 2. Date of Death Month April Day 23 Year 2004 | | 3. Time of Death 1430 M | |
| 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL Medical Center | | 4b. City, Town, or Location of Death Salisbury | | 4c. County of Death Wicomico | |
| 5. Social Security Number 214-28-2071 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 72 Yrs. | 8. Date of Birth (Month, Day, Year) 8-27-1931 | | 9. Birthplace (State or Foreign Country) Md. |
| Usual Residence of Decedent | | | | | |
| 10a. State Md. | 10b. County Worcester | 10c. City, Town or Location Snow Hill | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 4008 Paw Paw Creek Rd. | | 10f. Zip Code 21863 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Finance Officer | |
| 17. Father's Name (First, Middle, Last) Harry Smith | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Scotten Smith | | | |
| 19a. Informant's Name/Relationship (Type, Print) Evelyn Smith, Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4008 Paw Paw Creek Rd. Snow Hill, Md. 21863 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory of Delmarva | | 20c. Location - City or Town, State Delmar, De. | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Short Funeral Home, INC. Delmar, De. 19940 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC SARCOMA | | | | | Approximate Interval Between Onset and Death 10 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Robert L. Clinton, MD | | 29c. License number DA056776 | | 29d. Date signed (Month, Day, Year) 4/24/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT L CLINTON, MD 145 E. CARROLL Street Salisbury, Md. 21801 | | | | | |
| 31. Date filed (Month, Day, Year) APR 26 2004 | | 32. Registrar's Signature Geneva B Sparks | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15695

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARK DANIEL SMITH

2. Date of Death

Month

Day

Year

April

23

2004

3. Time of Death

0651 M

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

214-66-8337

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

08-17-1955

9. Birthplace (State or Foreign Country)

SALISBURY, MD.

Usual Residence of Decedent

10a. State

MD

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1253 MIDDLENECK DRIVE

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

PLUMBER

16b. Kind of Business/Industry

PLUMBING

17. Father's Name (First, Middle, Last)

JOHN E. SMITH

18. Mother's Name (First, Middle, Maiden Surname)

LOIS TAYLOR

19a. Informant's Name/Relationship (Type, Print)

ADELINE SMITH - SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1253 MIDDLENECK DRIVE, SALISBURY, MARYLAND 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

PARSONS CEMETERY

Date

04-27-2004

20c. Location - City or Town, State

SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee

Dennis Z Kelly

22. Name and Address of Facility

BOUNDS FUNERAL HOME, INC.

705 EAST MAIN STREET, SALISBURY, MARYLAND 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. CARDIO MYO PATHY

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown3 ☐ Ectopic pregnancy
5 ☐ Other (specify)23d. Date of delivery
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LOIP; RENAL FAILURE & OBESITY
KLINEFELTER'S SYNDROME

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an
autopsy
performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available
prior to completion of cause of
death?
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

D J Undermiller

29c. License number

020912

29d. Date signed (Month, Day, Year)

4-23-04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PENNIS CHADWICK, MD 4006 STATE DR. SALISBURY MD

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Benita B Sparks

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15496

1- For
State
RegistrarPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Carl Smith, Jr.

2. Date of Death

Month 4 Day 23 Year 2004 23:23^M

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENNSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

215-12-6690

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 19, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

101 Pacific Avenue

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

Navy

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Electrical Supply

17. Father's Name (First, Middle, Last)

William Carl Smith, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Sarah --- Hastings

19a. Informant's Name/Relationship (Type, Print)

Veronica Smith (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 Pacific Avenue, Salisbury, Maryland 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parsons Cemetery

Date

April 27, 2004

20c. Location - City or Town, State

Salisbury, Maryland

21. Signature of Funeral Service Licensee

David H. Compton CFSP

22. Name and Address of Facility

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

b. Bladder Adenoma

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

9 years

9 years

9 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William H. Robins

29c. License number

028349

29d. Date signed (Month, Day, Year)

4/25/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Robins 100 E. Carroll St. Salisbury, MD 21801

31. Date filed (Month, Day, Year)

APR 26 2004

32. Registrar's Signature

Benjamin P. Sparks

State
Registrar

William C. Smith Jr.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For Amend Item #4a, per Dr. G831, 5/13/2004, Reg. & #1
 State of Maryland / Department of Health and Mental Hygiene
 Certificate of Death
 2004 15497
 Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|------------------------------------|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILBUR ALLEN TAYLOR | | | 2. Date of Death Month Day Year 05 02 2004 | | 3. Time of Death 1:31 PM | | |
| | 4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 213-03-3333 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) May 22, 1918 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1520 Ramblewood Road | | 10f. Zip Code 21239 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dental Technician | | 16b. Kind of Business/Industry Prosthetic Artisan | | 17. Father's Name (First, Middle, Last) Jesse Allen Taylor | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Annie McCullough | | 19a. Informant's Name/Relationship (Type, Print) Rae L. Taylor/Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1520 Ramblewood Rd., Baltimore, MD 21239 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| Physician /Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Middletown Cemetery | | 20c. Location - City or Town, State Freeland, MD | | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | 23b. If FEMALE: Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) | | 23d. Date of delivery Month Day Year | |
| To Be Completed by Physician/Medical Examiner | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25a. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 25b. Date of Injury (Month, Day Year) | | 25c. Time of Injury M | | 25d. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 25f. Location (Street and Number or Rural Route Number, City or Town, State) | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Describe how injury occurred | |
| | 28a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 28b. Signature and title of certifier K. Srilatha MD | | 28c. License number RES000 | | 28d. Date signed (Month, Day, Year) 5/2/2004 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Srilatha SRILATHA KANUMURU 5601 LOCHRAVEN BLVD, BALTIMORE MD 21239 | | 31. Date filed (Month, Day, Year) MAY 13 2004 | | 32. Registrar's Signature | | 33. Date of Death 05 02 2004 | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State Registrar

ORIGINAL

Phillip Torsani
04-02956
RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For
State
Registrar

Unpaid Item #23627 per me 6832 6/2/04 tas

Certificate of Death

Reg. No. 2004 15498

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Philip Jay Torsani | | 2. Date of Death Month May Day 1 Year 2004 | | 3. Time of Death 0759 A M | |
| 4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital | | 4b. City, Town, or Location of Death Lanham | | 4c. County of Death Prince George's | |
| 5. Social Security Number 135-64-9887 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 41 Yrs. | |
| 8. Date of Birth (Month, Day, Year) Apr. 26, 1963 | | 9. Birthplace (State or Foreign Country) France | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County Prince George's | | 10c. City, Town or Location Bowie | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 12324 Rambling Lane | | 10f. Zip Code 20716 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Design Director | | 16b. Kind of Business/Industry Graphic Design | | 17. Father's Name (First, Middle, Last) Joseph A. Torsani | |
| 18. Mother's Name (First, Middle, Maiden Surname) Faith A. Hancock | | 19a. Informant's Name/Relationship (Type, Print) Wendy E. Torsani / spouse | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12324 Rambling Lane Bowie, MD. 20716 | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crem. | | 20c. Location - City or Town, State 5-6-2004 Alexandria, VA. | |
| 21. Signature of Funeral Service Licensee E. Brian Powell | | 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 20715 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Seizure Disorder Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | 23b. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown | | 23c. Date of delivery Month Day Year | |
| 23d. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Monty McShane | |
| 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) May 2, 2004 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRY P. KORON 111 Penn Street, Baltimore, Maryland 21201 | |
| 31. Date filed (Month, Day, Year) MAY 04 2004 | | 32. Registrar's Signature Mark A. Smith | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2004 15499

1- For
State
Registrar

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|--|--|--|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Roger N. Truehart | | | | 2. Date of Death Month Day Year April 24 2004 | | | | 3. Time of Death 9:00 pM | | | |
| | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital | | | | 4b. City, Town, or Location of Death Clinton | | | | 4c. County of Death Prince George | | | |
| Funeral Director | 5. Social Security Number 579-62-8507 | | 6. Sex 1X M 2□ F | | 7. Age (In yrs. last birthday) 56 Yrs. | | 8. Date of Birth (Month, Day, Year) July 5 1947 | | 9. Birthplace (State or Foreign Country) Washington DC | | | |
| | 10a. State DC | | | | 10b. County Washington | | | | 10c. City, Town or Location Washington | | | |
| To Be Completed by Funeral Director | 10e. Street and Number 314 Todd Place NE | | | | 10f. Zip Code 20002 | | | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1□ Never Married 2□ Married 3□ Widowed 4X Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1□ Yes 2X No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2X No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4yrs | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | | | 16b. Kind of Business/Industry Pvt Industry | | | |
| | 17. Father's Name (First, Middle, Last) Henry E. Truehart | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth Scott | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Nannie Gilliam (Sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Todd Place NE Washington, DC 20002 | | | | | | | |
| | 20a. Method of Disposition 1□ Burial 2X Cremation 3□ Removal from State 4□ Donation 5□ Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Park | | | | 20c. Location - City or Town, State May 01 2004 Riverdale Md. | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Tyrone J. Young | | | | 22. Name and Address of Facility Tyrone J. Young Fun Ser. 719 Kennedy St. NW | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Pancreatic Cancer | | | | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23c. Date of delivery Month Day Year 4/25/2004 | | | |
| To Be Completed by Physician/Medical Examiner | 23d. Immediate Cause (Final disease or condition resulting in death) Severe Anemia | | | | 23e. Did tobacco use contribute to the cause of death? 1□ Yes 2X No 3□ Probably 4□ Unknown | | | | 23f. Location (Street and Number or Rural Route Number, City or Town, State) Fort Washington MD 20744 | | | |
| | 23g. Underlying Cause (Disease or injury that initiated events resulting in death) Last Metastatic Pancreatic Cancer | | | | 23h. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2□ No | | | | 23i. Date signed (Month, Day, Year) 4/25/2004 | | | |
| To Be Completed by Physician/Medical Examiner | 24. Was case referred to medical examiner? 1□ Yes 2X No | | | | 25. Place of Death (Check only one) Hospital: 1X Inpatient 2□ ER/Outpatient 3□ DOA Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify) | | | | 26. Date of Injury (Month, Day Year) 4/25/2004 | | | |
| | 27. Manner of Death 1X Natural 2□ Accident 3□ Suicide 4□ Homicide 5□ Pending investigation 6□ Could not be determined | | | | 28a. Date of Injury (Month, Day Year) 4/25/2004 | | | | 28b. Time of Injury M | | | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work? 1□ Yes 2□ No | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Fort Washington MD 20744 | | | | 29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Paul Bone MD | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number D 46285 | | | | 29d. Date signed (Month, Day, Year) 4/25/2004 | | | | 29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL BONE, MD 10905 Fort Washington Rd. #206 | | | |
| | 30. Date filed (Month, Day, Year) APR 29 2004 | | | | 31. Registrar's Signature Paul Bone | | | | 32. Date signed (Month, Day, Year) 4/25/2004 | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 15500

1- For State Registrar

Physician /Medical Examiner

Funeral Director

| | | | | | | | |
|---|--|---|--|---|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last) WILLETTE C. THORNES | | | | 2. Date of Death Month 4 Day 26 Year 2004 | | 3. Time of Death 1:40 P M | |
| 4a. Facility Name (If not institution, give street and number) 7605 LOCRIS DRIVE | | | | 4b. City, Town, or Location of Death UPPER MARLBORO | | 4c. County of Death PRINCE GEORGE'S | |
| 5. Social Security Number 162-30-0777 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 70 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 26 1934 | 9. Birthplace (State or Foreign Country) South Carolina |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County PRINCE GEORGE'S | | 10c. City, Town or Location UPPER MARLBORO | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 7605 LOCRIS DRIVE | | | | 10f. Zip Code 20772 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Project Manager | | 16b. Kind of Business/Industry Private | |
| 17. Father's Name (First, Middle, Last) William H. Caldwell | | | | 18. Mother's Name (First, Middle, Maiden Surname) Flossie Stewart | | | |
| 19a. Informant's Name/Relationship (Type, Print) Evelyn Thornes/ Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7605 Locris Drive Upper Marlboro, Maryland 20772 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veteran's | | Date 5/5/2004 | | 20c. Location - City or Town, State Cheltenham, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 | | | |

To Be Completed by Funeral Director

Physician /Medical Examiner

| | | | | | |
|--|--|--|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Colon Cancer with Brain Metastasis Due to (or as a consequence of): b. Seizures Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | 23c. If yes, outcome of pregnancy <input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify) <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown | | 23d. Date of delivery Month Day Year | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23e. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Dr. Rosario Fernandez | | 29c. License number D19518 | | 29d. Date signed (Month, Day, Year) 4/27/04 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSARIO FERNANDEZ M.D. 7700 OLD BRANCH AVE. C102 CLINTON, MD. 20735 | | | | | |
| 31. Date filed (Month, Day, Year) APR 28 2004 | | 32. Registrar's Signature | | | |

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,